Public Operating Engineers Fund: Plan A PPO

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

Coverage Period: 01/01/2013 – 12/31/2013
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 by calling **1-800-844-8392.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No. There are no other specific **deductibles**.	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?	Yes, $3,000/person; $6,000/family. **This plan has no out-of-pocket limit on Non-Contract providers within the Contracted Service Area.**	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?	Premiums, balance-billed charges, health care this plan does not cover, copayments, charges in excess of annual maximum benefits, outpatient retail/mail order prescription drug expenses and coinsurance from Non-contract providers (except for hospital emergency room for an emergency medical condition) and Physician visits from an Out-of-Area provider (office, hospital, home) do not count toward the **out-of-pocket limit**.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	Yes, $2 million per person through December 31, 2013, then the Plan no longer has an overall annual limit on medical plan benefits.	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. For a list of **Blue Cross Prudent Buyer Plan Contract** providers, see **www.bluecrossca.com** or call 1-800-844-8392. For a list of **Blue Card Contract** providers outside the state of California, see **www.bluecares.com** or call 1-800-844-8392.	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.

Questions: Call 1-800-844-8392. 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 1-800-844-8392 to request a copy.

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

Common Medical Event	Services You May Need	Your Cost If You Use A Contract Provider	Your Cost If You Use an Out-of-Area Provider	Your Cost If You Use a Non-Contract Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copayment/visit	$10 copayment/visit, plus 10% coinsurance	$10 copayment/visit plus **40% coinsurance	Services must be medically necessary and are subject to plan limitations. In this chart, where you see "**" it means that for non-contract providers, you pay amounts above the Plan's allowed charge.
	Specialist visit	$10 copayment/visit	$10 copayment/visit, plus 10% coinsurance	$10 copayment/visit, plus **40% coinsurance	
	Other practitioner office visit	Chiropractor: 10% co-insurance, Acupuncture: $10 copayment/visit	Chiropractor: 10% coinsurance, Acupuncture: $10 copayment/visit, plus 10% coinsurance	Chiropractor: **40% co-insurance/visit, Acupuncture: $10 copayment/visit, plus **40% coinsurance	Chiropractor: max 40 visits/year (combined with PT).Acupuncture: maximum 1 visit/week, 12 weeks/diagnosis
	Preventive care/screening/im-munization	No charge	No charge for a routine exam ($150/exam), Mammogram 10% coinsurance	100% for routine exam ($150/exam), Mammogram **40% coinsurance	Plan covers preventive services/supplies required by the Health Reform law. Age and frequency guidelines apply.

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If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	10% coinsurance	**40% coinsurance	Imaging tests require pre-authorization by American Imaging Management.
	Imaging (CT/PET scans, MRIs)	10% co-insurance	10% coinsurance	**40% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available from Caremark at www.caremark.com or call (888) 790-4258	Generic drugs	Retail Pharmacy (34-day supply): $10 copayment; Mail Order (90-day supply): $5 copayment. Prescription contraceptives: No charge for generic drugs	You pay 100%. Then the Plan reimburses no more than it would have paid had you used a Contracted retail pharmacy. If cost of the drug is less than the copay, you pay just the drug cost.		Contract Caremark for information on prescriptions subject to preauthorization, step therapy. If you have your prescription filled with a brand name drug when a generic equivalent is available, the Fund will only pay up to the reasonable cost of the generic equivalent.
	Brand Name Drugs	Retail Pharmacy (34-day supply): $15 copayment; Mail Order (90-day supply): $10 copayment if no generic is available ($25 copayment if generic is available). Prescription contraceptives: No charge for brand drug if generic drug is medically inappropriate.			
	Specialty Drugs	Retail copays apply	Not covered (except for chemotherapy drugs)		Drug must be obtained through PBM
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	10% coinsurance	**20% coinsurance	Services must be medically necessary and are subject to plan limitations
	Physician/surgeon fees	10% coinsurance	10% coinsurance	**40% coinsurance	
If you need immediate medical attention	Emergency room services	10% co-insurance	10% coinsurance	**10% coinsurance	Services must be medically necessary and are subject to plan limitations
	Emergency medical transportation	20% co-insurance	20% coinsurance	**20% coinsurance	

Common Medical Event	Services You May Need	Your Cost If You Use A Contract Provider	Your Cost If You Use an Out-of-Area Provider	Your Cost If You Use a Non-Contract Provider	Limitations & Exceptions
	Urgent care	20% co-insurance	20% coinsurance	**20% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	10% coinsurance	**40% coinsurance	Elective hospital admission requires pre-authorization
	Physician/surgeon fee	Physician visit: $10 copayment, Surgeon: 10% coinsurance	Physician visit: $10 copayment, plus 10% coinsurance, Surgeon: 10% coinsurance	Physician Visit: $10 copayment, then **40% coinsurance, Surgeon: **40% coinsurance	Services must be medically necessary and are subject to plan limitations
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 copayment/visit	$10 copayment/visit, then 10% coinsurance	$10 copayment/visit, then **40% coinsurance	Services must be medically necessary and are subject to plan limitations
	Mental/Behavioral health inpatient services	10% coinsurance	10% coinsurance	**40% coinsurance	Elective hospital admission requires preauthorization
	Substance use disorder outpatient services	$10 copayment/visit	$10 copayment/visit, then 10% coinsurance	$10 copayment/visit, then **40% coinsurance	Services must be medically necessary and are subject to plan limitations
	Substance use disorder inpatient services	10% coinsurance	10% coinsurance	**40% coinsurance	Elective hospital admission requires preauthorization with ARP (Assistance Recovery Program)
If you are pregnant	Prenatal and postnatal care	No charge for office visits	10% coinsurance ($10 copay plus 10% coinsurance for office visits)	**40% coinsurance ($10 copay plus **40% coinsurance for office visits)	Ultrasound payable as a diagnostic test
	Delivery and all inpatient services	10% coinsurance	10% coinsurance	**40% coinsurance	Pre-authorization required for extended hospital stays. Pregnancy for dependent children not covered.

Common Medical Event	Services You May Need	Your Cost If You Use A Contract Provider	Your Cost If You Use an Out-of-Area Provider	Your Cost If You Use a Non-Contract Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	10% coinsurance	10% coinsurance	**10% coinsurance	Daily maximum 1 visit. 60 visits/calendar year.
	Rehabilitation services	10% coinsurance	10% coinsurance	**40% coinsurance	Outpatient PT max benefit is 40 visits/year (combined with Chiropractic). Speech therapy maximum $1,000/year
	Habilitation services	Not covered	Not covered	Not covered	You pay 100% of these expenses
	Skilled nursing care	10% coinsurance	10% coinsurance	**10% coinsurance	Max benefit 180 days/year. Preauthorization required.
	Durable medical equipment	20% coinsurance	20% coinsurance	**20% coinsurance	Services must be medically necessary and are subject to plan limitations
	Hospice service	10% coinsurance	10% coinsurance	**10% coinsurance	Daily maximum 1 visit, 60 visits/calendar year.
If your child needs dental or eye care	Eye exam	$7.50 copay	$7.50 copay/exam plus any amount over $45	$7.50 copay/exam plus any amount over $45	Limitations and frequency do not apply to children under 18.
	Glasses	No charge for single vision lenses. You pay any amount over $140 for frames	You pay any amount over $34 for single vision lenses and any amount over $70 for frames	You pay any amount over $34 for single vision lenses and any amount over $70 for frames	
	Dental check-up	No charge	No charge	No charge	Covered for children up to18 years under separate Delta Dental plan

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
- Habilitation Services
- Infertility treatment
- Long-term care
- 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 (maximum 1 visit/week, 12 visits/diagnosis)
- Bariatric Surgery (must be medically necessary)
- Chiropractic care (up to 40 visits/year combined with physical therapy)
- Dental care (Adult) under separate Delta Dental Plan up to $2,500/person
- Hearing aids (you pay 20% coinsurance up to $450/ear, every 3 years)
- Non-emergency care when traveling outside the U.S.
- Private duty nursing (if medically necessary)
- Routine eye care (Adult) under separate vision plan (VSP)
- Routine foot care (foot orthotics not covered)

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) 844-8392. 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 Fund Office at (800) 844-8392. 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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al (800) 844-8392.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 844-8392.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 (800) 844-8392.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 844-8392.

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** $6,940
- **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	$0
Copays	$60
Coinsurance	$510
Limits or exclusions	$30
Total	**$600**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,420
- **Patient pays** $980

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	$530
Coinsurance	$250
Limits or exclusions	$200
Total	**$980**

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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