

IDAHO PIPE TRADES TRUST

Administrative Office

Idaho Pipe Trades
Health & Welfare Trust
LU 296 & LU 648



Plumbers & Pipefitters
Pension Trust
LU 296 LU 648 LU 41

NEW MEMBER ENROLLMENT PACKET

Welcome to the Idaho Pipe Trades Health and Welfare Fund!

Dear Participant:

This enrollment package was sent to you because you are, or soon will be eligible for health care coverage. In order to better understand the benefits that are available to you, it is important that you carefully read all the information included in this package. This letter is a brief breakdown of some of the important information and forms that are enclosed in this package.

**** IT IS IMPORTANT THAT YOU FULLY AND LEGIBLY COMPLETE AND RETURN ALL REQUIRED DOCUMENTS AS SOON AS POSSIBLE SINCE ANY MISSING INFORMATION OR INCOMPLETE FORMS, WILL DELAY THE PROCESSING OF YOUR MEDICAL CLAIMS. ****

Enclosed in this package please find the following:

Enrollment Form – This is required for all participants. Only dependents listed on this form will have coverage from the Plan. Please complete accordingly, sign/date and return to the Trust Fund Office.

Coordination of Benefits Form - This is required for all participants. Complete this form if you, your spouse, or any of your dependents have/do not have, other health insurance coverage. If you and/or your dependent(s) ***do not*** have other coverage, please check the indicator box and sign/date the bottom of the page under “Member Statement” and return to the Trust Fund Office.

Authorization for Release of Protected Health Information – Please read the enclosed HIPAA and Protected Health Information (PHI) notice, which explains your rights and how and when protected information may be disclosed.

- *You may give permission for the Trust Fund to release your information to someone else by completing, signing and returning the Authorization for Release of Protected Health Information Form to the Trust Fund Office.*

Benefit Summary – Please refer to these sheets for a summary of the medical, dental, vision and prescription drug benefits available through the plan. Medical, dental, and vision is provided by Blue Cross of Idaho. Prescriptions are provided by Optum Rx.

If you (and or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. See pages 23-25 for more details.

You will also find other forms and information included in this packet. Please feel free to contact the Fund Office at (800) 808-1687 with any questions you may have.

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NEW MEMBER PACKET CHECK LIST

FORMS TO BE RETURNED TO THE TRUST FUND OFFICE:

(It may not be necessary to complete all of the listed below, depending on your coverage choices. Please contact the Trust Fund Office if you should have any questions regarding your enrollment.)

- Enrollment Form** This is required for all Participants. You must complete, sign, and return to the Trust Fund Office within 60 days of when you are first eligible.
- Coordination of Benefits Form** Please complete both pages, sign, and return with your Enrollment Form to the Trust Fund Office.
- Authorization for Release of Protected Health Information** It is strongly recommended that you, your spouse and your eligible dependents over the age of 18 complete the Authorization for Release of Protected Health Information Form.
- Marriage Certificate** If you are married, please submit a photo copy of your marriage certificate to add your current spouse.
- Birth Certificates** Please submit photo copies of birth certificates for: You, your Spouse; and any Dependent Children you wish to enroll onto the Plan (including step-children, and adopted children).

****PLEASE RETURN ALL FORMS TO****

**IDAHO PIPE TRADES TRUST FUNDS
PMB #116 5331 SW MACADAM AVE SUITE 258
PORTLAND, OR 97239**

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HEALTH & WELFARE PLAN ENROLLMENT FORM

Due Within 60 DAYS of when you are first eligible

CHECK ALL THAT APPLY: New Enrollment Adding Dependents Dropping Dependents Address Change

EMPLOYEE'S FULL LEGAL NAME: _____ SSN: _____

LOCAL UNION NO. _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ GENDER: (Circle One) Male Female

DATE OF BIRTH: _____ PHONE NUMBER: (_____) _____ EMAIL: _____

MARITAL STATUS: Married (Date of Marriage) _____ Single Divorced (Date of Divorce) _____

MEDICAL/PRESCRIPTION, DENTAL, AND VISION PLAN:

MEDICAL, DENTAL & VISION - BLUECROSS OF IDAHO (Group# 10034808)
PRESCRIPTION – Optum Rx (Group# PSI2839)

NOTE: If you, your spouse, or any of your dependents are on Medicare or Medicare Eligible, please include a copy of your Medicare Card.

IMPORTANT: If your Spouse works at least 20 hours per week or 80 hours per month and has group insurance coverage available through an employer but does not elect that coverage, your Spouse will not be considered an Eligible Dependent and the Plan will not cover your Spouse's claims for benefits under the Plan. This applies whether or not your Spouse must pay for the other coverage. (See SPD Pages 9-11.)

NOTIFYING THE PLAN OF OTHER COVERAGE CHANGES: If you or your spouse or dependents become eligible for and/or enrolled in or loses other group health coverage you are required to notify IPTT in writing within 60 days by completing a Health & Welfare Plan Change Form. Failure to notify IPTT of other coverage changes and/or any false statements or misrepresentation on this form is considered fraudulent and may result in retroactively terminating plan coverage and you will be responsible for reimbursement for all amounts paid in connection with such coverage. See page 46 of the SPD.

DEPENDENTS - (Including Spouse)

YOU MUST ATTACH LEGAL DOCUMENTATION THAT APPLIES TO ADD YOUR DEPENDENTS:

Birth Certificate(s) for children, Marriage Certificate for spouse, Legal Adoption papers, Legal Guardianship papers

| OTHER COVERAGE | FULL NAME | RELATIONSHIP | DATE OF BIRTH | SSN | GENDER |
|--|-----------|--------------|---------------|-------|--------|
| Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ | _____ | _____ | _____ | _____ |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ | _____ | _____ | _____ | _____ |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ | _____ | _____ | _____ | _____ |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ | _____ | _____ | _____ | _____ |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ | _____ | _____ | _____ | _____ |

DECLARATION: I have provided the above information to the very best of my knowledge. I declare under penalty of perjury under the laws of the United States of America **that the foregoing is true and correct.** I understand Section 1027 of Title 18 of the United States Code makes it a crime to knowingly make a false statement in any document required to be kept by or certified to the administrator of a pension or health/welfare plan. I further understand that the punishment for violation of this law can be both a fine up to \$10,000 and imprisonment for as long as five years.

ACKNOWLEDGMENT: I understand and acknowledge that in order to process claims for benefits, physicians, hospitals or other medical providers may share information with Idaho Pipe Trades Health & Welfare Trust or their representatives regarding my or my dependents' health history, symptoms, treatment, examination results or diagnosis.

EMPLOYEE SIGNATURE _____ **DATE** _____

SPOUSE SIGNATURE _____ **DATE** _____

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Coordination of Benefits

Member's Name: _____ Member ID #: _____ Date of Birth: _____

Address: _____

*If you and/or spouse/dependents **DO NOT** have any other insurance coverage, please check this box turn over and sign/date the bottom of the next page (under "Member Statement").*

INCOMPLETE DOCUMENTATION WILL RESULT IN POSSIBLE DELAYS IN CLAIMS PROCESSING

A

MEMBER HEALTH COVERAGE INFORMATION

Does this plan include **Medical** Coverage? Yes or No If yes, is this plan an: HMO or PPO

Name of Medical/Rx Carrier: _____ Policyholder name: _____ Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____ Group Number: _____

Does this plan include **Dental** Coverage? Yes or No If yes, is this plan an: HMO or PPO

Name of Dental Carrier: _____ Policyholder name: _____ Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____ Group Number: _____

Does this plan include **Vision** Coverage? Yes or No If yes, is this plan an: HMO or PPO

Name of Vision Carrier: _____ Policyholder name: _____ Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____ Group Number: _____

Medicare: Policyholder name: _____ Policy Number: _____

Is coverage because of? Age Disability ESRD

Part: A B C D Effective Date: A) _____ B) _____ C) _____ D) _____

B

SPOUSE AND DEPENDENTS HEALTH COVERAGE INFORMATION

Does this plan include **Medical** Coverage? Yes or No If yes, is this plan an: HMO or PPO

Name of Medical/Rx Carrier: _____ Policyholder name: _____ Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____ Group Number: _____

Does this plan include **Dental** Coverage? Yes or No If yes, is this plan an: HMO or PPO

Name of Dental Carrier: _____ Policyholder name: _____ Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____ Group Number: _____

Does this plan include **Vision** Coverage? Yes or No If yes, is this plan an: HMO or PPO

Name of Vision Carrier: _____ Policyholder name: _____ Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____ Group Number: _____

Medicare: Policyholder name: _____ Policy Number: _____

Is coverage because of? Age Disability ESRD

Part: A B C D Effective Date: A) _____ B) _____ C) _____ D) _____

1.) **Dependent:** _____

Medical/Rx Effective Date: _____ **Dental** Effective Date: _____ **Vision** Effective Date: _____

• Name of **Medical/Rx** Carrier: _____ Policyholder name: _____ Policy Number: _____

• Name of **Dental** Carrier: _____ Policyholder name: _____ Policy Number: _____

• Name of **Vision** Carrier: _____ Policyholder name: _____ Policy Number: _____

2.) **Dependent:** _____

Medical/Rx Effective Date: _____ **Dental** Effective Date: _____ **Vision** Effective Date: _____

• Name of **Medical/Rx** Carrier: _____ Policyholder name: _____ Policy Number: _____

• Name of **Dental** Carrier: _____ Policyholder name: _____ Policy Number: _____

• Name of **Vision** Carrier: _____ Policyholder name: _____ Policy Number: _____

Continuation on other Side

For additional dependents, ATTACH A SEPARATE sheet with employee's name at top. (Last, First, MI)

3.) Dependent: _____

Medical/Rx Effective Date: _____ **Dental** Effective Date: _____ **Vision** Effective Date: _____

• Name of **Medical/Rx** Carrier: _____ Policyholder name: _____ Policy Number: _____

• Name of **Dental** Carrier: _____ Policyholder name: _____ Policy Number: _____

• Name of **Vision** Carrier: _____ Policyholder name: _____ Policy Number: _____

4.) Dependent: _____

Medical Effective Date: _____ **Dental** Effective Date: _____ **Vision** Effective Date: _____

• Name of **Medical/Rx** Carrier: _____ Policyholder name: _____ Policy Number: _____

• Name of **Dental** Carrier: _____ Policyholder name: _____ Policy Number: _____

• Name of **Vision** Carrier: _____ Policyholder name: _____ Policy Number: _____



FILL OUT THIS SECTION ONLY IF YOUR CHILD(REN) HAVE ADDITIONAL HEALTHCARE COVERAGE DUE TO •DIVORCE •SEPARATION •COURT ORDER •MEDICARE OR •OTHER FEDERAL-STATE HEALTH INSURANCE PROGRAMS.

*****(Indicate which child by marking appropriate circle)** ***

1.) Is child(ren) covered by Medicare or other Federal-State coverage? Yes or No (If yes which child)? 1 2 3 4

Medicare: Policyholder name: _____ Policy Number: _____

Is coverage because of? Age Disability ESRD

Part: A B C D Effective Date: A) _____ B) _____ C) _____ D) _____

Medi-Cal/Medicaid: Policyholder name: _____ Policy Number: _____

2.) Does one parent/guardian have full custody of the child(ren): Yes or No (If yes which child)? 1 2 3 4

Parent: _____ **Date:** _____

3.) Is one parent required by court decree to provide health insurance for child(ren): Yes or No 1 2 3 4

Parent: _____ **Date:** _____

Name of person responsible for child's healthcare coverage? _____

Employer: _____ Date of Birth: _____

Insurance Company name: _____ Insurance Company City & State: _____

Insurance Company Phone Number: _____ Enrollee ID/ policy number: _____

Group Number: _____ Effective date: _____ Cancellation date (if applicable): _____

******If court decree is present please PROVIDE A COPY of the court documents******

Member Statement: The above information is true and accurate to the best of my knowledge and belief. I am also aware of the fact that I must notify the Fund Office immediately should any of the dependents listed on my coverage become eligible for any other coverage. Any materials submitted by myself or on behalf of any eligible person that contains a material alteration or forged or false information, including signatures, will be rejected. The Trustees reserve the right to refer such matters to Fund Legal Counsel for appropriate action. This will not limit the right of the Fund to recover any losses it suffers because of such material in any matter.

Signature: _____ **Phone #:** _____ **Date:** _____

Below is the HIPAA Notice of Privacy Practices Availability Notice:

The Idaho Pipe Trades Trust maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. You have the right to request a copy of the Plan's Notice of Privacy Practices from the Trust Administrative Office by submitting a written request to: PMB#116, 5331 SW Macadam Avenue Suite 258, Portland, OR 97239. You may also obtain a copy of this notice on the Plan's website: <http://www.IPTT.org>.

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Instructions for completing the

Authorization for Release of Protected Health Information

There is a section for the Member/Retiree, Spouse and if applicable, a section for a dependent child(ren) over the age of 18.

Member Section /Retiree Section

1. Fill in your name and social security number.
2. **If you are married** and you want to give your spouse authority to inquire about your health information, please enter his/her name and relationship (spouse) –or- **If you are not married or you want to give someone other than your spouse** authority to inquire about your health information, please enter his/her name and relationship (mother, father, friend, etc.).
3. **If you are giving someone else authority, please sign and date form.**

OR

If you do not want to give anyone other than yourself authority to inquire about your health information, then place an “X” in the box where it says “I do not want my Health Information released to anyone but myself”. **Please sign and date below the box.**

Spouse Section

1. Fill in your name and social security number.
2. **If you want to give your spouse (member/retiree)** authority to inquire about your health information, please enter his/her name and relationship (spouse). **If you want to give someone other than your spouse** authority to inquire about your health information, please enter his/her name and relationship (mother, father, friend, etc.), **please sign and date form.**

OR

If you do not want to give anyone other than yourself authority to inquire about your health information, then place an “X” in the box where it says “I do not want my Health Information released to anyone but myself”.

3. **Please sign and date form below the box.**
-

Dependent(s) over the age of 18 Section

1. Fill in your name and social security number.
2. **If you want to give your parents** authority to inquire about your health information, please enter their name and relationship (father, mother). **If want to give someone other than your parents** authority to inquire about your health information, please enter his/her name and relationship (mother, father, friend, etc.) **please sign and date form.**

OR

If you do not want to give anyone other than yourself authority to inquire about your health information, then place an “X” in the box where it says “I do not want my Health Information released to anyone but myself”.

3. **Please sign and date form below the box.**

-OVER-

Authorization for Release of Protected Health Information

MEMBER/RETIREE SECTION

I, (print your name and Social Security number) _____ authorize the Health and Welfare Plan (the "Plan"), and its business associates, to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired), at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that this authorization will expire upon termination of my enrollment in the Plan, unless I revoke it sooner. I understand that I have the right to revoke it at any time, except to the extent that it has already been relied upon. I understand that if I decide to revoke this authorization, I must give notice of my decision in writing and send it to:

Idaho Pipe Trades Trust (IPTT) H&W Plan
PMB#116, 5331 SW Macadam Avenue Suite 258
Portland, OR 97239
Phone 208-288-1610 • Toll Free 800-808-1687 • Fax 208-288-1670
www.iptt.org

I understand that my health information that is disclosed pursuant to this authorization may be re-disclosed by the persons I have identified above, and the Plan cannot prevent or protect such re-disclosures, AND I understand that I am not required to sign this form to receive my health care benefits (enrollment, treatment or payment).

Signature of Member _____ **Date Signed:** _____

-OR- I do not want my Health Information released to anyone but myself.

Signature of Member _____ **Date Signed:** _____

SPOUSE SECTION

I, the spouse (Name, Please Print) _____, (Spouse's Social Security #) _____ of the above named member, have also read, understand, and authorize the Plan to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired) for the reasons and with the explanations listed above, at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Spouse _____ **Date Signed:** _____

-OR- I do not want my Health Information released to anyone but myself.

Signature of Spouse _____ **Date Signed:** _____

DEPENDENT(S) OVER THE AGE OF 18 SECTION

I, the dependent child(ren) over the age of 18 (Name, Please Print) _____, (Social Security #) _____ have also read, understand, and authorize the Plan to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired) for the reasons and with the explanations listed above, except at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Dependent _____ **Date Signed:** _____

OR- I do not want my Health Information released to anyone but myself.

Signature of Dependent _____ **Date Signed:** _____

NOTE: If there is more than one dependent over the age of 18, please copy, complete and sign the appropriate number of additional Authorization Forms and return to the Benefit Office.



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. Note: Information about the cost of the [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, 1-800-627-1188. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined](#) terms see the Glossary. You can view the Glossary as www.healthcare.gov/sbc-glossary or call 1-800-627-1188 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|--|
| What is the overall deductible ? | \$750 person/\$2,250 family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible . |
| Are there services covered before you meet your deductible ? | Yes. Pharmacy, services that require copays , dental, vision, diabetes education, hearing aid services or In-network listed Preventive care are covered before you meet your deductible . | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services ? | Yes. \$150 for dental services. There are no other specific deductibles . | 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. |
| What is the out-of-pocket limit for this plan ? | For In-network provider \$3,720 person / \$7,440 family. For Out-of-network provider \$7,500 person. For prescription drugs \$2,880 person / \$5,760 family. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit ? | Premiums , hearing aid services, adult dental, vision, balance-billing charges and health care this plan doesn't cover, and Out-of-network deductibles and copays . | Even though you pay these expenses, they don't count toward the out-of-pocket limit . |
| Will you pay less if you use a network provider ? | Yes. See www.bcidaho.com or call 1-800-627-1188 for a list of network providers . | This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an Out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an Out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a referral to see a Specialist ? | No. | You can see the Specialist you choose without a referral . |



All [copayments](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|--|--|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$25 copay /visit, 20% coinsurance | \$25 copay /visit, 30% coinsurance | Does not apply to additional services. |
| | Specialist visit | \$25 copay /visit, 20% coinsurance | \$25 copay /visit, 30% coinsurance | Does not apply to additional services. |
| | Preventive care/screening /immunization | No charge for listed preventive, screening and immunization services. deductible does not apply. | 30% coinsurance immunizations, preventive and screening . | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | 20% coinsurance | 30% coinsurance | ----- none ----- |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 30% coinsurance | ----- none ----- |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.OptumRx.com | Generic drugs | \$20 | The difference between the Contracted Rate (rate of in-network provider) and the provider charge plus copay . | OptumRx Mail Service Pharmacy has a \$40 copay for a 90 day supply. Special provisions apply to maintenance drugs. |
| | Preferred brand drugs | \$40 | The difference between the Contracted Rate (rate of in-network provider) and the provider charge plus copay . | OptumRx Mail Service Pharmacy has a \$80 copay for a 90 day supply. Special provisions apply to maintenance drugs. |
| | Non-preferred brand drugs | \$70 | The difference between the Contracted Rate (rate of in-network provider) and the provider charge plus copay . | OptumRx Mail Service Pharmacy has a \$140 copay for a 90 day supply. Special provisions apply to maintenance drugs. |
| | Specialty drugs | 10% or \$120 max copay (One 30 day supply at retail) | | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|---|---|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 30% coinsurance | ----- none ----- |
| | Physician/surgeon fees | 20% coinsurance | 30% coinsurance | ----- none ----- |
| If you need immediate medical attention | Emergency room care | \$100 copay /visit, 20% coinsurance | \$100 copay /visit, 30% coinsurance | Out-of-network services paid at In-network if Emergency medical condition . copay waived if admitted. |
| | Emergency medical transportation | 20% coinsurance | 30% coinsurance | ----- none ----- |
| | Urgent care | \$25 copay /visit, 20% coinsurance | \$25 copay /visit, 30% coinsurance | Does not apply to additional services. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance | 30% coinsurance | No benefits for Transplant Services. |
| | Physician/surgeon fee | 20% coinsurance | 30% coinsurance | ----- none ----- |
| If you have mental health, behavioral health, or substance abuse services | Outpatient services | \$25 copay visit, 20% coinsurance visit facility and other services | \$25 copay visit, 30% coinsurance visit facility and other services | Some services may require Preauthorization . |
| | Inpatient services | 20% coinsurance | 30% coinsurance | Some services may require Preauthorization . No benefits for Out-of-network Inpatient Residential Treatment Facility or Alcohol and Substance Abuse Rehabilitation. |
| If you are pregnant | Office Visits | 20% coinsurance | 30% coinsurance | For pregnancy services, cost sharing does not apply to certain preventive services . Depending on the type of services, a copay , coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 20% coinsurance | 30% coinsurance | ----- none ----- |
| | Childbirth/delivery facility services | 20% coinsurance | 30% coinsurance | ----- none ----- |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need help recovering or have other special health needs | Home health care | 20% coinsurance | 30% coinsurance | Coverage is limited to 70 days/illness (combined with Skilled Nursing). |
| | Rehabilitation services | 20% coinsurance , or 50% coinsurance for speech | 30% coinsurance , or 50% coinsurance for speech | Coverage is limited to 24 visit annual max for habilitation and Rehabilitation services . Additional limitations may apply. |
| | Habilitation services | 20% coinsurance , or 50% coinsurance for speech | 30% coinsurance , or 50% coinsurance for speech | Coverage is limited to 24 visit annual max for habilitation and Rehabilitation services . Additional limitations may apply. |
| | Skilled nursing care | 20% coinsurance | Not covered | Coverage is limited to 70 days/illness (combined with Home Health). |
| | Durable medical equipment | 20% coinsurance | 30% coinsurance | Preauthorization required for purchase. |
| | Hospice services | 20% coinsurance | 30% coinsurance | ----- none ----- |
| If your child needs dental or eye care | Children's eye exam | No charge | 50% coinsurance | Quantity and frequency limits apply. |
| | Children's glasses | No charge | 50% coinsurance | Quantity and frequency limits apply. |
| | Children's dental check-up | 20% coinsurance | 20% coinsurance | ----- none ----- |

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of other [excluded services](#).)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Infertility treatment
- Long-term care
- Organ and Tissue Transplant Services
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Chiropractic care
- Dental care (Adult)
- Hearing aids (employee only)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

Your Rights to Continue Coverage:

** Group health coverage -

There are agencies that can help if you want to continue coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-4444-EBSA(3272) or www.dol.gov/ebsa/healthreform; or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance through Your Health Idaho. For more information about Your Health Idaho, visit www.YourHealthIdaho.org or call 1-855-944-3246.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your [plan](#) for a denial of [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact:

For any initial questions concerning a claim, or to appeal a claim or benefit decision, please contact Customer Service at 1-208-331-7347 or 1-800-627-1188, www.bcidaho.com, or at P.O. Box 7408, Boise, ID 83707.

If your plan is subject to ERISA, you may contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA or www.dol.gov/ebsa/healthreform

If your plan is fully insured or self-funded and subject to the Idaho Insurance Code, you may also receive assistance from the Idaho Department of Insurance at 1-800-721-3272 or www.DOI.Idaho.gov

Does this plan provide Minimum Essential Coverage? **Yes.**

If you don't have [Minimum Essential Coverage](#) for a month, you will have to make payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for the month.

Does this plan meet the Minimum Value Standards? **Yes.**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$750
- [Specialist copay](#) \$25
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost \$12,731

In this example, Peg would pay:

Cost Sharing

| | |
|-------------|---------|
| Deductible | \$750 |
| Copayments | \$40 |
| Coinsurance | \$2,370 |

What isn't Covered

| | |
|----------------------|------|
| Limits or exclusions | \$60 |
|----------------------|------|

The total Peg would pay is \$3,220

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$750
- [Specialist copay](#) \$25
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost \$7,389

In this example, Joe would pay:

Cost Sharing

| | |
|-------------|---------|
| Deductible | \$130 |
| Copayments | \$1,620 |
| Coinsurance | \$0 |

What isn't Covered

| | |
|----------------------|------|
| Limits or exclusions | \$55 |
|----------------------|------|

The total Joe would pay is \$1,805

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$750
- [Specialist copay](#) \$25
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost \$1,930

In this example, Mia would pay:

Cost Sharing

| | |
|-------------|-------|
| Deductible | \$750 |
| Copayments | \$140 |
| Coinsurance | \$70 |

What isn't Covered

| | |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

The total Mia would pay is \$960

Nondiscrimination Statement: Discrimination is Against the Law

Blue Cross of Idaho complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Blue Cross of Idaho does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Blue Cross of Idaho:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Blue Cross of Idaho's Customer Service Department. Call 1-800-627-1188 (TTY: 1-800-377-1363), or call the customer service phone number on the back of your card.

If you believe that Blue Cross of Idaho has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with Blue Cross of Idaho's Grievances and Appeals Department at:

Manager, Grievances and Appeals
3000 East Pine Avenue, Meridian, Idaho 83642
Telephone: (800) 274-4018 ext.3838, Fax: (208) 331-7493
Email: grievances&appeals@bcidaho.com
TTY: 1-800-377-1363

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Grievances and Appeals team is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TTY).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>. Reference: <https://federalregister.gov/a/2016-11458>

Language Assistance

ATTENTION: If you speak Arabic, Chinese, French, German, Korean, Japanese, Persian (Farsi), Romanian, Russian, Serbo-Croatian, Spanish, Sudanic Fulfulde, Tagalog, Ukrainian, or Vietnamese, language assistance services, free of charge, are available to you. Call 1-800-627-1188 (TTY: 1-800-377-1363).

Arabic

اهتف الصم والابكم: (1-800-377-1363). ملاحظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-627-1188 (رقم

Chinese 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-627-1188 (TTY：1-800-377-1363)。

French ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-627-1188 (ATS : 1-800-377-1363).

German ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-627-1188 (TTY: 1-800-377-1363).

Japanese 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-627-1188 (TTY: 1-800-377-1363) まで、お電話にてご連絡ください。

Korean 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-627-1188 (TTY: 1-800-377-1363)번으로 전화해 주십시오.

Persian-Farsi

فرا مه می دشار. با 1-800-627-1188 تماس بگیرد. توجه: گار به ایزن فارسی گفتگو می دینک، تسهیلات ی نابز و صیرت اگیارن بریا شما

Romanian ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-627-1188 (TTY: 1-800-377-1363).

Russian ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-627-1188 (телетайп: 1-800-377-1363).

Serbo-Croatian OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-627-1188 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-377-1363).

Spanish ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-627-1188 (TTY: 1-800-377-1363).

Sudanese Fulfulde MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-800-627-1188 (TTY: 1-800-377-1363).

Tagalog PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-627-1188 (TTY: 1-800-377-1363).

Ukrainian УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-627-1188 (телетайп: 1-800-377-1363).

Vietnamese CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-627-1188 (TTY: 1-800-377-1363).

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Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- **Bold blue** text indicates a term defined in this Glossary.
- See page 4 for an example showing how **deductibles**, **coinsurance** and **out-of-pocket limits** work together in a real life situation.

Allowed Amount

Maximum amount on which payment is based for covered healthcare services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your **provider** charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing**.)

Appeal

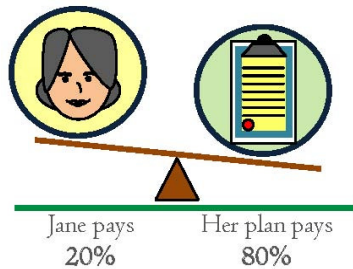
A request for your health insurer or **plan** to review a decision or a **grievance** again.

Balance Billing

When a **provider** bills you for the difference between the provider's charge and the **allowed amount**. For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. A **preferred provider** may not balance bill you for covered services.

Coinsurance

Your share of the costs of a covered healthcare service, calculated as a percent (for example, 20%) of the **allowed amount** for the service. You pay coinsurance plus any **deductibles** you owe. For example, if the **health insurance** or **plan's** allowed amount for an office visit is \$100 and you've met your deductible, your coinsurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount.



Complications of Pregnancy

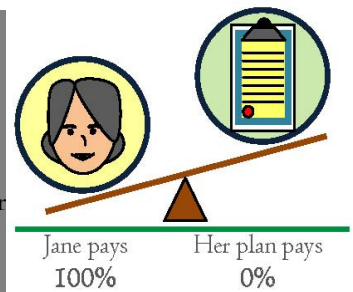
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Copayment

A fixed amount (for example, \$15) you pay for a covered healthcare service, usually when you receive the service. The amount can vary by the type of covered healthcare service.

Deductible

The amount you owe for healthcare services your **health insurance** or **plan** covers before your health insurance or plan begins to pay. For example, if your deductible is \$1000, your plan won't pay anything until you've met



your \$1000 deductible for covered healthcare services subject to the deductible. The deductible may not apply to all services.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a healthcare **provider** for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition

An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation

Ambulance services for an **emergency medical condition**.

Emergency Room Care

Emergency services you get in an emergency room.

Emergency Services Evaluation of an **emergency medical condition** and treatment to keep the condition from getting worse.

Excluded Services

Healthcare services that your **health insurance** or **plan** doesn't pay for or cover.

Grievance

A complaint that you communicate to your health insurer or **plan**.

Habilitation Services

Healthcare services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires your health insurer to pay some or all of your healthcare costs in exchange for a **premium**.

Home Healthcare

Healthcare services a person receives at home.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

In-network Coinsurance

The percent (for example, 20%) you pay of the **allowed amount** for covered healthcare services to **providers** who contract with your **health insurance** or **plan**. In-network coinsurance usually costs you less than **out-of-network coinsurance**.

In-network Copayment

A fixed amount (for example, \$15) you pay for covered healthcare services to **providers** who contract with your **health insurance** or **plan**. In-network copayments usually are less than **out-of-network copayments**.

Medically Necessary

Healthcare services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network (In-Network)

The facilities, **providers** and suppliers your health insurer or **plan** has contracted with to provide healthcare services.

Non-Preferred Provider (Out-of-Network)

A **provider** who doesn't have a contract with your health insurer or **plan** to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your **health insurance** or **plan**, or if your health insurance or plan has a "tiered" **network** and you must pay extra to see some providers.

Out-of-network Coinsurance

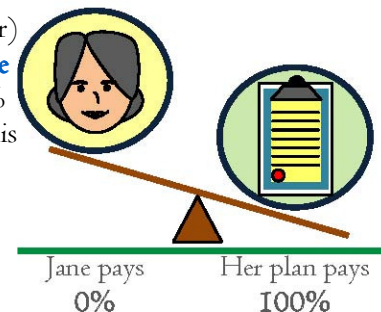
The percent (for example, 40%) you pay of the **allowed amount** for covered healthcare services to providers who do not contract with your **health insurance** or **plan**. Out-of-network coinsurance usually costs you more than **in-network coinsurance**.

Out-of-network Copayment

A fixed amount (for example, \$30) you pay for covered healthcare services from providers who do not contract with your **health insurance** or **plan**. Out-of-network copayments usually are more than **in-network co-payments**.

Out-of-Pocket Limit (Out-of-Pocket Maximum)

The most you pay during a policy period (usually a year) before your **health insurance** or **plan** begins to pay 100% of the **allowed amount**. This limit never includes your **premium**, **balance-billed** charges or healthcare your insurance or plan doesn't cover. Some health insurance (see page 4 for a detailed example.) or plans don't count all of your **copayments**, **deductibles**, **coinsurance** payments, out-of-network payments or other expenses toward this limit.



Physician Services

Healthcare services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan

A benefit your employer, union or other group sponsor provides to you to pay for your healthcare services.

Preauthorization

A decision by your health insurer or **plan** that a healthcare service, treatment plan, **prescription drug** or **durable medical equipment** is **medically necessary**. Sometimes called prior authorization, prior approval or precertification. Your **health insurance** or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider

A **provider** who has a contract with your health insurer or **plan** to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your **health insurance** or plan has a "tiered" **network** and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium

The amount that must be paid for your **health insurance** or **plan**. You and/or your employer usually pay it monthly, quarterly or yearly and your portion may be deducted from your paycheck.

Prescription Drug Coverage

Health insurance or **plan** that helps pay for **prescription drugs** and medications.

Prescription Drugs

Drugs and medications that by law require a prescription.

Primary Care Physician

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of healthcare services for a patient.

Primary Care Provider (PCP)

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of healthcare services.

Provider

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), healthcare professional or healthcare facility licensed, certified or accredited as required by state law.

Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services

Healthcare services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care

Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist

A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a **provider** who has more training in a specific area of healthcare.

UCR (Usual, Customary and Reasonable)

The amount paid for a medical service in a geographic area based on what **providers** in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the **allowed amount**.

Urgent Care

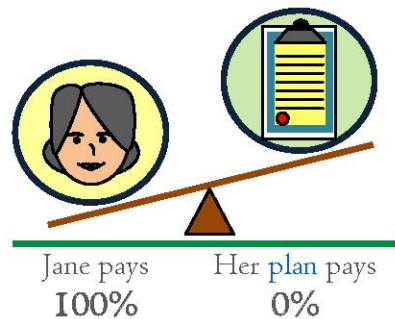
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require **emergency room care**.

How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: \$1,500 Coinsurance: 20% Out-of-Pocket Limit (Maximum): \$5,000

January 1st
Beginning of Coverage
Period

December 31st
End of Coverage Period



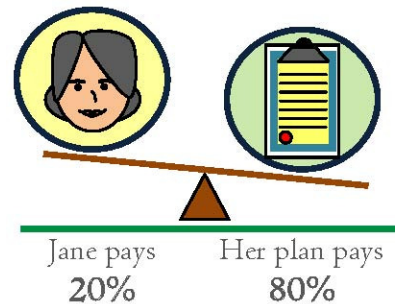
Jane hasn't reached her \$1500 deductions yet

Her plan doesn't pay any of the costs.

Office visit cost: \$125

Jane pays: \$125

Her plan pays: \$0



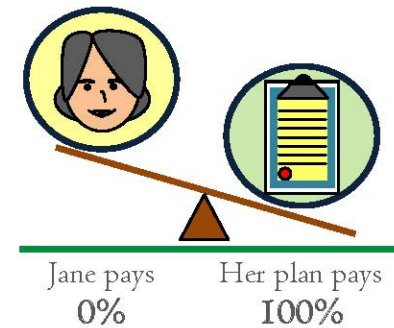
Jane reaches her \$1,500 deductible, co-insurance begins

Jane has seen a doctor several times and paid \$1,500 in total. Her plan pays some of the costs for her next visit.

Office visit costs: \$75

Jane pays: 20% of \$75 = \$15

Her plan pays: 80% of \$75 = \$60



Jane reaches her \$5,000 out-of-pocket limit

Jane has seen the doctor often and paid \$5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: \$200

Jane pays: \$0

Her plan pays: \$200

Important Notice from Idaho Pipe Trades Trust About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Idaho Pipe Trades Trust and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like a HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Idaho Pipe Trades Trust has determined that the prescription drug coverage offered by OptumRx is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If you Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Idaho Pipe Trades Trust coverage may be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

If you are covered by the Trust as an active employee, or spouse of an active employee, and you decide to enroll in a Medicare prescription drug plan, your coverage under the Trust will not be affected. The Trust will continue to be your primary coverage for prescription drugs.

If you are covered by the Trust as a retiree, or spouse of a retiree, and decide to enroll in a Medicare prescription drug plan, you will receive prescription drug benefits from the Medicare plan only. The Trust will not pay secondary benefits for prescription drugs, and the amount you must pay to the Trust for other health coverage will not change.

Your current coverage pays for other health expenses, in addition to prescription drugs. If you choose to enroll in a Medicare prescription drug plan, you will still be eligible to receive all of your other current health benefits by continuing to pay the required monthly amount to the Trust.

If you decide not to enroll in a Medicare prescription drug plan

If you make the decision not to enroll in a Medicare prescription drug plan, your prescription drug benefits will continue through the Trust plan.

You should compare your current coverage through the Trust, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

Idaho Pipe Trades prescription drug benefit

The Trust plan covers prescription drugs through the OptumRx drug card program. This program features a network of participating pharmacies for your convenience. When you use a pharmacy within the OptumRx network, you simply take your prescription and your OptumRx drug card to the pharmacy and make the appropriate co-payment to receive up to a 30 day supply. Co-payments are as follows:

| Type of Drug | Co-payment |
|---------------------|---------------------------|
| Generic | \$20.00 |
| Preferred Brand | \$40.00 |
| Non-Preferred Brand | \$70.00 |
| Specialty Drugs | 10% co-pay up to \$120.00 |

If you choose to purchase a brand name drug when a generic equivalent is available, the plan will only pay the amount it would have paid for the generic drug. In addition to the copay listed above, you will have to pay the additional cost of the brand drug.

For maintenance drugs – those drugs you use on an ongoing basis and that are listed on the OptumRx maintenance drug list – you are able to fill a 90 day prescription for two times the regular Retail co-payments for all tiers through the mail order program. If you choose to not use mail order for your maintenance drugs, you need to opt out of the mail order program and you can fill only a 30 day supply.

If you fill your prescription at a pharmacy outside the network, the same co-payments apply but you must pay the full cost when you make the purchase. Then, submit a claim form and the receipt to OptumRx for reimbursement. These claims will be reimbursed at the negotiated pharmacy rate, less the appropriate co-payment. However, prescriptions filled at Wal-Mart are not eligible for reimbursement.

If you do decide to join a Medicare drug plan and drop your Idaho Pipe Trades Trust prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your coverage with Idaho Pipe Trades Trust and don't join a Medicare drug plan within 63 continuous days after your coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have the coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **NOTE:** You'll get a notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Idaho Pipe Trades Trust changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

| | |
|--------------------------|---|
| Date: | October 14, 2016 |
| Name of Entity/Sender: | Idaho Pipe Trades Health and Welfare Trust Trust |
| Contact-Position/Office: | Administrative Office |
| Address: | PMB# 116, 5331 SW Macadam Ave., Suite 258 Portland, OR 97239 |
| Phone Number: | 208-288-1610 or 800-808-1687 |

Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. Contact your State for more information on eligibility –

| | |
|---|---|
| ALABAMA – Medicaid | FLORIDA – Medicaid |
| Website: http://myalhipp.com/ Phone: 1-855-692-5447 | Website: http://flmedicaidtprecovery.com/hipp/ Phone: 1-877-357-3268 |
| ALASKA – Medicaid | GEORGIA – Medicaid |
| The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx | Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507 |
| ARKANSAS – Medicaid | INDIANA – Medicaid |
| Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447) | Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864 |
| COLORADO – Medicaid | IOWA – Medicaid |
| Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943 | Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562 |

| | |
|--|--|
| KANSAS – Medicaid | NEVADA – Medicaid |
| Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512 | Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900 |
| KENTUCKY – Medicaid | NEW HAMPSHIRE – Medicaid |
| Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570 | Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218 |
| LOUISIANA – Medicaid | NEW JERSEY – Medicaid and CHIP |
| Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447 | Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 |
| MAINE – Medicaid | NEW YORK – Medicaid |
| Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711 | Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831 |
| MASSACHUSETTS – Medicaid and CHIP | NORTH CAROLINA – Medicaid |
| Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120 | Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100 |
| MINNESOTA – Medicaid | NORTH DAKOTA – Medicaid |
| Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739 | Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825 |
| MISSOURI – Medicaid | OKLAHOMA – Medicaid and CHIP |
| Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005 | Website: http://www.insureoklahoma.org Phone: 1-888-365-3742 |
| MONTANA – Medicaid | OREGON – Medicaid |
| Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 | Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075 |
| NEBRASKA – Medicaid | PENNSYLVANIA – Medicaid |
| Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633 | Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462 |

| | |
|--|---|
| <p align="center">RHODE ISLAND – Medicaid</p> <p>Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300</p> | <p align="center">VIRGINIA – Medicaid and CHIP</p> <p>Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282</p> |
| <p align="center">SOUTH CAROLINA – Medicaid</p> <p>Website: http://www.scdhhs.gov Phone: 1-888-549-0820</p> | <p align="center">WASHINGTON – Medicaid</p> <p>Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473</p> |
| <p align="center">SOUTH DAKOTA - Medicaid</p> <p>Website: http://dss.sd.gov Phone: 1-888-828-0059</p> | <p align="center">WEST VIRGINIA – Medicaid</p> <p>Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability</p> |
| <p align="center">TEXAS – Medicaid</p> <p>Website: http://gethipptexas.com/ Phone: 1-800-440-0493</p> | <p align="center">WISCONSIN – Medicaid and CHIP</p> <p>Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002</p> |
| <p align="center">UTAH – Medicaid and CHIP</p> <p>Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669</p> | <p align="center">WYOMING – Medicaid</p> <p>Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531</p> |
| <p align="center">VERMONT– Medicaid</p> <p>Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427</p> | |

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

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NOTICE OF NONDISCRIMINATION

Idaho Pipe Trades Health & Welfare Trust (“the Health Plan”) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Health Plan:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact the Health Plan 800-808-1687 and ask for assistance.

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

If you, or someone you’re helping, has questions about Idaho Pipe Trades Health and Welfare Plan, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (800) 808-1687.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Idaho Pipe Trades Health and Welfare Plan, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al (800) 808-1687.

如果您，或是您正在協助的對象，有關於[插入SBM項目的名稱 Idaho Pipe Trades Health and Welfare Plan 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字(800) 808-1687。

Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Idaho Pipe Trades Health and Welfare Plan, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite (800) 808-1687.

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Idaho Pipe Trades Health and Welfare Plan 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는(800) 808-1687로 전화하십시오.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Idaho Pipe Trades Health and Welfare Plan, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi (800) 808-1687.

Idaho Pipe Trades Health and Welfare Plan فلدیک الحق فی الحصول علی المساعدة والمعلومات

(800) 808-1687. إن كان لديك أو لدى شخص تساعد أسئلة بخصوص

الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل ب

Falls Sie oder jemand, dem Sie helfen, Fragen zum Idaho Pipe Trades Health and Welfare Plan haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer (800) 808-1687 an.

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Idaho Pipe Trades Health and Welfare Plan, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa (800) 808-1687.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Idaho Pipe Trades Health and Welfare Plan, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону (800) 808-1687.

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Idaho Pipe Trades Health and Welfare Plan, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez (800) 808-1687.

ご本人様、またはお客様の身の回りの方でも、Idaho Pipe Trades Health and Welfare Plan についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、(800) 808-1687 までお電話ください。

Dacă dumneavoastră sau persoana pe care o asistați aveți întrebări privind Idaho Pipe Trades Health and Welfare Plan, aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a vorbi cu un interpret, sunați la (800) 808-1687.

To aan, malla goddo mo mballata, e yama dow Idaho Pipe Trades Health and Welfare Plan, a woodi baawde hebuki habaru malla wallireeki wolde maada naa maa a yobii. Mbolda e pirtoowo, nodda (800) 808-1687.

Idaho Pipe Trades Health and Welfare Plan، داشته باشید حق این را دارید که کمک

اگر شما، یا کسی که شما به او کمک میکنید، سوال در مورد

و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. (800) 808-1687 تماس حاصل نمایید.

Якщо у Вас чи у когось, хто отримує Вашу допомогу, виникають питання про Idaho Pipe Trades Health and Welfare Plan у Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб зв'язатись з перекладачем, задзвоніть на (800) 808-1687.

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IDAHO PIPE TRADES TRUST

Administrative Office

Idaho Pipe Trades
Health & Welfare Trust
LU 296 & LU 648



Plumbers & Pipefitters
Pension Trust
LU 296 LU 648 LU 41

October 2016

Women's Health and Cancer Rights Act of 1998

On October 21, 1998, Congress passed the "Women's Health and Cancer Rights Act of 1998." Under this law, health plans must provide the following coverage after a mastectomy, as determined in consultation with the attending physician and the patient, for:

- All Stages of reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the healthy breast to produce a symmetrical (balanced) appearance; and
- Prosthesis (artificial replacement); and
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

These benefits will be subject to the same deductibles and co-payments applicable to other medical and surgical benefits provided under this Plan.

If you have any questions, please contact the Trust Administrative office at 208-288-1610 or 800-808-1687 for more information.

If you have any questions about this law, please contact the Trust Administrative office at one 208-288-1610 or 800-808-1687.

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IDAHO PIPE TRADES TRUST

Administrative Office

Idaho Pipe Trades
Health & Welfare Trust
LU 296 & LU 648



Plumbers & Pipefitters
Pension Trust
LU 296 LU 648 LU 41

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- Information written in other languages

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If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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ATTENTION: FOR FREE LANGUAGE ASSISTANCE CALL 1 (800) 808-1687

| Language | Message About Language Assistance |
|--|---|
| Español Spanish | ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1 (800) 808-1687. |
| 繁體中文 Chinese | 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1 (800) 808-1687. |
| Deutsch German | ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1 (800) 808-1687. |
| Tiếng Việt Vietnamese | CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1 (800) 808-1687. |
| 한국어 Korean | 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1 (800) 808-1687 전화해 주십시오. |
| العربية Arabic | ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1 (800) 808-1687. |
| Français French | ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1 (800) 808-1687. |
| Srpsko-hrvatski Serbo-Croatian | OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1 (800) 808-1687 |
| Tagalog Filipino | PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1 (800) 808-1687 |
| Українська Ukrainian | УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1 (800) 808-1687 |
| Română Romanian | ATENȚIE: Dacă vorbiți i limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați i la 1 (800) 808-1687 |
| Русский Russian | ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1 (800) 808-1687. |
| Adamawa Fulfulde | MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1 (800) 808-1687 |
| فارسی Farsi | توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1 (800) 808-1687 تماس بگیرید. |
| 日本語 Japanese | 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 1 (800) 808-1687 まで、お電話にてご連絡ください。 |