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 AND NO LONGER THAN 60 DAYS FROM YOUR COVERAGE EFFECTIVE DATE 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 29-32 for more details.

You will also find other forms and information included in this packet. Please feel free to contact the Fund Office at (208) 288-1610 or toll free (800) 808-1687 with any questions you may have.
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 legal marriage certificate to add your current spouse.

☐ **Birth Certificates**
   Please submit photo copies of legal birth certificates for: Any Dependent Children you wish to enroll onto the Plan (including step-children, and adopted children).

**PLEASE RETURN ALL FORMS BY MAIL TO**
IDAHO PIPE TRADES TRUST FUNDS
PMB #116 5331 SW MACADAM AVE SUITE 258
PORTLAND, OR 97239

**RETURN FORMS VIA EMAIL**
IPTT@BENESYS.COM
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 ☐ No ☐ ____________________________ ____________________________ ☐ Single ☐ Divorced ________________

Yes ☐ No ☐ ____________________________ ____________________________ ☐ Single ☐ Divorced ________________

Yes ☐ No ☐ ____________________________ ____________________________ ☐ Single ☐ Divorced ________________

Yes ☐ No ☐ ____________________________ ____________________________ ☐ Single ☐ Divorced ________________

Yes ☐ No ☐ ____________________________ ____________________________ ☐ Single ☐ Divorced ________________

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 ________________

PMB #116 · 5331 SW Macadam Avenue Suite 258, · Portland, OR 97239
Telephone (800) 808-1687 or (208) 288-1610 · FAX (208)288-1670
www.iptt.org
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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

### MEMBER HEALTH COVERAGE INFORMATION

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Yes or No</th>
<th>Plan Type</th>
<th>Carrier Information</th>
<th>Group Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>Yes or No</td>
<td>HMO or PPO</td>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Dental</td>
<td>Yes or No</td>
<td>HMO or PPO</td>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Vision</td>
<td>Yes or No</td>
<td>HMO or PPO</td>
<td>Name</td>
<td></td>
</tr>
</tbody>
</table>

Medicare: Policyholder name: ___________________ Policy Number: ___________________

Is coverage because of? □ Age □ Disability □ ESRD

Part: A □ B □ C □ D □ Effective Date: A) ___________ B) ___________ C) ___________ D) ___________

### SPOUSE AND DEPENDENTS HEALTH COVERAGE INFORMATION

<table>
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<td></td>
</tr>
<tr>
<td>Dental</td>
<td>Yes or No</td>
<td>HMO or PPO</td>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Vision</td>
<td>Yes or No</td>
<td>HMO or PPO</td>
<td>Name</td>
<td></td>
</tr>
</tbody>
</table>

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) ___________

medic-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.**
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
Email: iptt@benesys.com
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, visit [https://members.bcidadaho.com/my-account/my-account-my-contract.page](https://members.bcidadaho.com/my-account/my-account-my-contract.page). 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 at [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-800-627-1188 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall Deductible?</td>
<td>$500 person/$1,500 family</td>
<td>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.</td>
</tr>
<tr>
<td>Are there services covered before you meet your Deductible?</td>
<td>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.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other Deductibles for specific services?</td>
<td>Yes. $75 for dental services. There are no other specific Deductibles.</td>
<td>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.</td>
</tr>
<tr>
<td>What is the Out-of-pocket Limit for this Plan?</td>
<td>For In-Network Provider $3,720 person / $7,440 family. For Out-of-Network Provider $7,500 person / $5,760 family.</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the Out-of-pocket Limit?</td>
<td>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.</td>
<td>Even though you pay these expenses, they don’t count toward the Out-of-pocket Limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a Network Provider?</td>
<td>Yes. See <a href="http://www.bcidadaho.com">www.bcidadaho.com</a> or call 1-800-627-1188 for a list of Network Providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a Referral to see a Specialist?</td>
<td>No.</td>
<td>You can see the Specialist you choose without a Referral.</td>
</tr>
</tbody>
</table>

Questions: Call 1-800-627-1188 or visit us at [www.bcidadaho.com](http://www.bcidadaho.com)/SBC.
All **copayments** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td><strong>Network Provider</strong> (You will pay the least)</td>
<td><strong>Out-of-Network Provider</strong> (You will pay the most)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$25 <strong>Copay</strong>/visit, 20% <strong>Coinsurance</strong></td>
<td>$25 <strong>Copay</strong>/visit, 30% <strong>Coinsurance</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Does not apply to additional services.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist visit</td>
<td>$25 <strong>Copay</strong>/visit, 20% <strong>Coinsurance</strong></td>
<td>$25 <strong>Copay</strong>/visit, 30% <strong>Coinsurance</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Does not apply to additional services.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Care/Screening/immunization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No charge for listed preventive, Screening and immunization services. <strong>Deductible</strong> does not apply.</td>
<td>30% <strong>Coinsurance</strong> immunizations, preventive and Screening.</td>
<td><strong>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.</strong></td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Test (x-ray, blood work)</td>
<td>20% <strong>Coinsurance</strong></td>
<td>30% <strong>Coinsurance</strong></td>
<td><strong>none</strong></td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% <strong>Coinsurance</strong></td>
<td>30% <strong>Coinsurance</strong></td>
<td><strong>none</strong></td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic drugs</td>
<td>$20</td>
<td>The difference between the Contracted Rate (rate of <strong>In-Network Provider</strong>) and the <strong>Provider</strong> charge plus <strong>Copay</strong>.</td>
<td><strong>OptumRx Mail Service Pharmacy has a $40 <strong>Copay</strong> for a 90 day supply. Special provisions apply to maintenance drugs.</strong></td>
</tr>
<tr>
<td>Preferred brand drugs</td>
<td>$40</td>
<td>The difference between the Contracted Rate (rate of <strong>In-Network Provider</strong>) and the <strong>Provider</strong> charge plus <strong>Copay</strong>.</td>
<td><strong>OptumRx Mail Service Pharmacy has a $80 <strong>Copay</strong> for a 90 day supply. Special provisions apply to maintenance drugs.</strong></td>
</tr>
<tr>
<td>Non-preferred brand drugs</td>
<td>$70</td>
<td>The difference between the Contracted Rate (rate of <strong>In-Network Provider</strong>) and the <strong>Provider</strong> charge plus <strong>Copay</strong>.</td>
<td><strong>OptumRx Mail Service Pharmacy has a $140 <strong>Copay</strong> for a 90 day supply. Special provisions apply to maintenance drugs.</strong></td>
</tr>
<tr>
<td>Specialty Drugs</td>
<td>10% or $120 max <strong>Copay</strong> (One 30 day supply at retail)</td>
<td></td>
<td><strong>One fill allowed at retail for a specialty medication; after that must be filled through OptumRx Specialty Mail Service Pharmacy.</strong></td>
</tr>
</tbody>
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Questions: Call 1-800-627-1188 or visit us at www.bcidaho.com/SBC.
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<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>Network Provider (You will pay the least): 20% Coinsurance</td>
<td>Out-of-Network Provider (You will pay the most): 30% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% Coinsurance</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency Room Care</td>
<td>$100 Copay/visit, 20% Coinsurance</td>
<td>$100 Copay/visit, 20% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Emergency Medical Transportation</td>
<td>20% Coinsurance</td>
<td>20% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent Care</td>
<td>$25 Copay/visit, 20% Coinsurance</td>
<td>$25 Copay/visit, 30% Coinsurance</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% Coinsurance</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>20% Coinsurance</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>$25 Copay visit, 20% Coinsurance visit facility and other services</td>
<td>$25 Copay visit, 30% Coinsurance visit facility and other services</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% Coinsurance</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office Visits</td>
<td>20% Coinsurance</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% Coinsurance</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% Coinsurance</td>
<td>30% Coinsurance</td>
</tr>
</tbody>
</table>

Questions: Call 1-800-627-1188 or visit us at www.bcidadaho.com/SBC.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td><strong>Home Health Care</strong></td>
<td>20% <strong>Coinsurance</strong></td>
<td>30% <strong>Coinsurance</strong></td>
<td>Coverage is limited to 70 days/illness (combined with Skilled Nursing).</td>
</tr>
<tr>
<td></td>
<td><strong>ReHabilitation Services</strong></td>
<td>20% <strong>Coinsurance</strong>, or 50% <strong>Coinsurance</strong> for speech</td>
<td>30% <strong>Coinsurance</strong>, or 50% <strong>Coinsurance</strong> for speech</td>
<td>Coverage is limited to 24 visit annual max for habilitation and ReHabilitation Services. Additional limitations may apply.</td>
</tr>
<tr>
<td></td>
<td><strong>Habilitation Services</strong></td>
<td>20% <strong>Coinsurance</strong>, or 50% <strong>Coinsurance</strong> for speech</td>
<td>30% <strong>Coinsurance</strong>, or 50% <strong>Coinsurance</strong> for speech</td>
<td>Coverage is limited to 24 visit annual max for habilitation and ReHabilitation Services. Additional limitations may apply.</td>
</tr>
<tr>
<td></td>
<td><strong>Skilled Nursing Care</strong></td>
<td>20% <strong>Coinsurance</strong></td>
<td>Not covered</td>
<td>Coverage is limited to 70 days/illness (combined with Home Health).</td>
</tr>
<tr>
<td></td>
<td><strong>Durable Medical Equipment</strong></td>
<td>20% <strong>Coinsurance</strong></td>
<td>30% <strong>Coinsurance</strong></td>
<td>Preauthorization required for purchase.</td>
</tr>
<tr>
<td></td>
<td><strong>Hospice Services</strong></td>
<td>20% <strong>Coinsurance</strong></td>
<td>30% <strong>Coinsurance</strong></td>
<td>——————————————————————————————————— none ———————————————————————————————————</td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td><strong>Children’s eye exam</strong></td>
<td>No charge</td>
<td>50% <strong>Coinsurance</strong></td>
<td>Quantity and frequency limits apply.</td>
</tr>
<tr>
<td></td>
<td><strong>Children’s glasses</strong></td>
<td>No charge</td>
<td>50% <strong>Coinsurance</strong></td>
<td>Quantity and frequency limits apply.</td>
</tr>
<tr>
<td></td>
<td><strong>Children’s dental check-up</strong></td>
<td>No charge</td>
<td>No charge</td>
<td>——————————————————————————————————— none ———————————————————————————————————</td>
</tr>
</tbody>
</table>

Questions: Call 1-800-627-1188 or visit us at www.bcidadaho.com/SBC.
**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
- 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)

Questions: Call 1-800-627-1188 or visit us at www.bcidaho.com/SBC.
** 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.bcidadaho.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.DOLIdaho.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.

---

** Questions:** Call 1-800-627-1188 or visit us at www.bcidadaho.com/SBC.
### 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**: $500
- **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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$40</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,620</td>
</tr>
</tbody>
</table>

**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**: $500
- **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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$130</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,620</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**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**: $500
- **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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$130</td>
</tr>
<tr>
<td>Copayments</td>
<td>$140</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$320</td>
</tr>
</tbody>
</table>

**What isn't Covered**

| Limits or exclusions | $0 |

**The total Mia would pay is**: $960

---

**Questions:** Call 1-800-627-1188 or visit us at [www.bcidaho.com/SBC](http://www.bcidaho.com/SBC).

The plan would be responsible for the other costs of these EXAMPLE covered services.
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).


Questions: Call 1-800-627-1188 or visit us at www.bcidaho.com/SBC.
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).
YOUR LIFE IS 24/7. WITH VIRTUAL CARE, YOUR DOCTOR IS, TOO.

Avoid the wait! Activate your Blue Cross of Idaho MDLive account today at mdlive.com/bcidaho.

When you can’t see your primary care provider, you can consult with a board-certified doctor by phone, secure video or the MDLIVE app anytime, from anywhere. If you are in Idaho, you will need to use video to meet with the doctor.

MDLIVE doctors are available 24/7/365. Average wait time for medical consultations is less than 10 minutes. Therapists and psychiatrists require an appointment, with an average wait time of three to four days.

Your family members are eligible for virtual care, too. Pediatricians are available 24/7.

 activates your account online or by phone. mdlive.com/bcidaho 888-920-2975

**NON-EMERGENCY CONDITIONS WE TREAT:**
- Acne
- Allergies
- Cold / Flu
- Constipation
- Cough
- Diarrhea
- Ear problems
- Fever*
- Headache
- Insect bites
- Nausea / Vomiting
- Pink eye
- Rash
- Respiratory problems
- Sore throats
- Urinary problems / UTI*
- Vaginitis
- And more

**Behavioral Health**
- Addictions
- Bipolar disorders
- Child and adolescent issues
- Depression
- Eating disorders
- Gay/Lesbian/Bisexual/Transgender issues
- Grief and loss
- Life changes
- Men's issues
- Panic disorders
- Parenting issues
- Postpartum depression
- Relationship and marriage issues
- Stress
- Trauma and PTSD
- Women’s issues
- And more

E-prescriptions can be sent to your preferred pharmacy

(continued)
MDLIVE physicians may not treat any children with urinary symptoms. Parents/guardian will be required to complete a different medical history disclosure form for children under the age of 36-months prior to making an appointment with an MDLIVE physician. Children under 36 months who present with fever must be referred to their pediatrician (medical home), child-friendly urgent care center or emergency department for clinical evaluation and care.

MDLIVE does not provide any healthcare services and is not an insurance product or a prescription fulfillment warehouse. MDLIVE does not replace your relationship with your primary care provider. MDLIVE operates subject to state regulation and may not be available in certain states. MDLIVE does not guarantee that a prescription will be written. MDLIVE does not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. Contents in this material are not a substitute for professional healthcare advice, diagnosis or treatment. MDLIVE healthcare professionals reserve the right to deny care for potential misuse of services. MDLIVE and the MDLIVE logo are registered trademarks of MDLIVE, Inc. and may not be used without written permission. For complete terms of use visit www.mdlive.com/pages/terms.html.

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Welcome to MDLIVE! Your anytime, anywhere doctor’s office.
Avoid waiting rooms and the inconvenience of going to the doctor’s office. Visit a doctor by phone*, secure video or the MDLIVE App. Family members are eligible and pediatricians are available 24/7.

Meet Sophie!
Your personal health assistant! Sophie makes creating an account quick and easy using your smartphone. It’s easy to register - anytime, anywhere!

Steps To Connect to Chatbot:
1. Text bcidaho to 635483.
2. Tap to load preview. You will also be presented with Stop/Help language.
3. Tap “Let’s Chat” to launch a web browser page which simulates a texting conversation.

*MDLIVE services for medical consultations are limited in Idaho to video consultations only with the ability to prescribe. In Arkansas, an initial visit must be completed via video. After an initial visit, subsequent consultations may be completed via phone.

MDLIVE.com/bcidaho
888-920-2975

MDLIVE® is an independent company that enables the virtual visit between the member and doctor on behalf of Blue Cross of Idaho. Copyright © 2018 MDLIVE Inc. All Rights Reserved. MDLIVE may not be available in certain states and is subject to state regulations.
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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 deductible, coinsurance and out-of-pocket limit 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 deductible 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 $1,000, your plan won’t pay anything until you’ve met your $1,000 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.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
Glossary of Health Coverage and Medical Terms
Page 1 of 4
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 copayments.

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 health insurance or plan doesn’t cover. Some health insurance 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.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Glossary of Health Coverage and Medical Terms
Page 2 of 4
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.

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.

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.

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.

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.

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.

Preferred Provider
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.

Prescription Drug Coverage
Health insurance or plan that helps pay for prescription drugs and medications.

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.

Prescription Drugs
Drugs and medications that by law require a prescription.

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.

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.

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.

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.

Glossary of Health Coverage and Medical Terms

UCR (Usual, Customary and Reasonable)

Provider

Primary Care Physician

Preauthorization

Rehabilitation Services

Preferred Provider

Prescription Drug Coverage

Specialist

Primary Care Provider (PCP)

Premium

Prescription Drugs

Plan

Preauthorization

Provider

Preferred Provider

Prescription Drug Coverage

Primary Care Physician

Primary Care Provider (PCP)
How You and Your Insurer Share Costs - Example

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

Jane hasn’t reached her $1,500 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

Office visit cost: $200
Jane pays: $0
Her plan pays: $200

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.
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:

<table>
<thead>
<tr>
<th>Type of Drug</th>
<th>Co-payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>$20.00</td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>$40.00</td>
</tr>
<tr>
<td>Non-Preferred Brand</td>
<td>$70.00</td>
</tr>
<tr>
<td>Specialty Drugs</td>
<td>10% co-pay up to $120.00</td>
</tr>
</tbody>
</table>
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 13, 2019
Name of Entity/Sender: Idaho Pipe Trades Health and Welfare Trust
Contact-Position/Office: Trust Administrative Office
Address: PMB #116
5331 SW Macadam Avenue Ste 258
Portland, OR 97239
Phone Number: 208-228-1610 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, 2019. Contact your State for more information on eligibility –

<table>
<thead>
<tr>
<th>State</th>
<th>Program Name</th>
<th>Website</th>
<th>Phone</th>
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<tbody>
<tr>
<td>ALABAMA – Medicaid</td>
<td>Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a> Phone: 1-855-692-5447</td>
<td>Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a> Phone: 1-855-692-5447</td>
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</tr>
<tr>
<td>FLORIDA – Medicaid</td>
<td>Website: <a href="http://flmedicaidtplrecovery.com/hipp/">http://flmedicaidtplrecovery.com/hipp/</a> Phone: 1-877-357-3268</td>
<td>Website: <a href="http://flmedicaidtplrecovery.com/hipp/">http://flmedicaidtplrecovery.com/hipp/</a> Phone: 1-877-357-3268</td>
<td></td>
</tr>
<tr>
<td>ALASKA – Medicaid</td>
<td>Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a> Phone: 1-866-251-4861 Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a> Medicaid Eligibility: <a href="http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx">http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</a></td>
<td>Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a> Phone: 1-866-251-4861 Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a> Medicaid Eligibility: <a href="http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx">http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</a></td>
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<tr>
<td>GEORGIA – Medicaid</td>
<td>Website: <a href="https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp">https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp</a> Phone: 678-564-1162 ext 2131</td>
<td>Website: <a href="https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp">https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp</a> Phone: 678-564-1162 ext 2131</td>
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<tr>
<td>INDIANA – Medicaid</td>
<td>Healthy Indiana Plan for low-income adults 19-64 Website: <a href="http://www.in.gov/fssa/hip/">http://www.in.gov/fssa/hip/</a> Phone: 1-877-438-4479 All other Medicaid Website: <a href="http://www.indianamedicaid.com">http://www.indianamedicaid.com</a> Phone 1-800-403-0864</td>
<td>Healthy Indiana Plan for low-income adults 19-64 Website: <a href="http://www.in.gov/fssa/hip/">http://www.in.gov/fssa/hip/</a> Phone: 1-877-438-4479 All other Medicaid Website: <a href="http://www.indianamedicaid.com">http://www.indianamedicaid.com</a> Phone 1-800-403-0864</td>
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<tr>
<td>IOWA – Medicaid</td>
<td>Website: <a href="http://dhs.iowa.gov/Hawki">http://dhs.iowa.gov/Hawki</a> Phone: 1-800-257-8563</td>
<td>Website: <a href="http://dhs.iowa.gov/Hawki">http://dhs.iowa.gov/Hawki</a> Phone: 1-800-257-8563</td>
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<tr>
<td>State</td>
<td>Program</td>
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<tr>
<td>NEW HAMPSHIRE</td>
<td>Medicaid</td>
<td><a href="https://www.dhhs.nh.gov/oii/hipp.htm">https://www.dhhs.nh.gov/oii/hipp.htm</a></td>
<td>603-271-5218; Toll free: 1-800-852-3345, ext 5218</td>
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<tr>
<td>KENTUCKY</td>
<td>Medicaid</td>
<td><a href="https://chfs.ky.gov">https://chfs.ky.gov</a></td>
<td>1-800-635-2370</td>
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<tr>
<td>LOUISIANA</td>
<td>Medicaid</td>
<td><a href="http://dhhs.louisiana.gov/index.cfm/subhome/1/n/331">http://dhhs.louisiana.gov/index.cfm/subhome/1/n/331</a></td>
<td>1-888-695-2447</td>
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<tr>
<td>NEW YORK</td>
<td>Medicaid</td>
<td><a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a></td>
<td>1-800-541-2831</td>
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<tr>
<td>NORTH CAROLINA</td>
<td>Medicaid</td>
<td><a href="https://medicaid.ncdhhs.gov/">https://medicaid.ncdhhs.gov/</a></td>
<td>919-855-4100</td>
</tr>
<tr>
<td>OKLAHOMA</td>
<td>Medicaid and CHIP</td>
<td><a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a></td>
<td>1-888-365-3742</td>
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<tr>
<td>MISSOURI</td>
<td>Medicaid</td>
<td><a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a></td>
<td>573-751-2005</td>
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<tr>
<td>PENNSYLVANIA</td>
<td>Medicaid</td>
<td><a href="http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm">http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm</a></td>
<td>1-800-692-7462</td>
</tr>
<tr>
<td>MONTANA</td>
<td>Medicaid</td>
<td><a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPPP</a></td>
<td>1-800-694-3084</td>
</tr>
<tr>
<td>RHODE ISLAND</td>
<td>Medicaid and CHIP</td>
<td><a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a></td>
<td>855-697-4347; 401-462-0311 (Direct Rdte Share Line)</td>
</tr>
<tr>
<td>NEVADA</td>
<td>Medicaid</td>
<td><a href="https://dhcfp.nv.gov">https://dhcfp.nv.gov</a></td>
<td>1-800-992-0900</td>
</tr>
<tr>
<td>SOUTH CAROLINA</td>
<td>Medicaid</td>
<td><a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a></td>
<td>1-888-549-0820</td>
</tr>
</tbody>
</table>
To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor  
Employee Benefits Security Administration  
www.dol.gov/agencies/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

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To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

**SOUTH DAKOTA - Medicaid**

Website: [http://dss.sd.gov](http://dss.sd.gov)  
Phone: 1-888-828-0059

**WASHINGTON – Medicaid**

Website: [https://www.hca.wa.gov/](https://www.hca.wa.gov/)  
Phone: 1-800-562-3022 ext. 15473

**TEXAS – Medicaid**

Website: [http://gethipptexas.com/](http://gethipptexas.com/)  
Phone: 1-800-440-0493

**WEST VIRGINIA – Medicaid**

Website: [http://mywvhipp.com/](http://mywvhipp.com/)  
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

**UTAH – Medicaid and CHIP**

Medicaid Website: [https://medicaid.utah.gov/](https://medicaid.utah.gov/)  
CHIP Website: [http://health.utah.gov/chip](http://health.utah.gov/chip)  
Phone: 1-877-543-7669

**WISCONSIN – Medicaid and CHIP**

Website: [https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf](https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf)  
Phone: 1-800-362-3002

**VERMONT – Medicaid**

Website: [http://www.greenmountaincare.org/](http://www.greenmountaincare.org/)  
Phone: 1-800-250-8427

**WYOMING – Medicaid**

Website: [http://mywvhipp.com/](http://mywvhipp.com/)  
Toll-free phone: 1-855-MyWVHIP (1-855-699-8447)

**VIRGINIA – Medicaid and CHIP**

Medicaid Website: [http://www.coverva.org/programs_premium_assistance.cfm](http://www.coverva.org/programs_premium_assistance.cfm)  
Medicaid Phone: 1-800-432-5924  
CHIP Website: [http://www.coverva.org/programs_premium_assistance.cfm](http://www.coverva.org/programs_premium_assistance.cfm)  
CHIP Phone: 1-855-242-8282

**WASHINGTON – Medicaid**

Website: [https://www.hca.wa.gov/](https://www.hca.wa.gov/)  
Phone: 1-800-562-3022 ext. 15473

**TEXAS – Medicaid**

Website: [http://gethipptexas.com/](http://gethipptexas.com/)  
Phone: 1-800-440-0493

**WEST VIRGINIA – Medicaid**

Website: [http://mywvhipp.com/](http://mywvhipp.com/)  
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

**UTAH – Medicaid and CHIP**

Medicaid Website: [https://medicaid.utah.gov/](https://medicaid.utah.gov/)  
CHIP Website: [http://health.utah.gov/chip](http://health.utah.gov/chip)  
Phone: 1-877-543-7669

**WISCONSIN – Medicaid and CHIP**

Website: [https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf](https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf)  
Phone: 1-800-362-3002

**VERMONT – Medicaid**

Website: [http://www.greenmountaincare.org/](http://www.greenmountaincare.org/)  
Phone: 1-800-250-8427

**WYOMING – Medicaid**

Website: [http://mywvhipp.com/](http://mywvhipp.com/)  
Toll-free phone: 1-855-MyWVHIP (1-855-699-8447)

**VIRGINIA – Medicaid and CHIP**

Medicaid Website: [http://www.coverva.org/programs_premium_assistance.cfm](http://www.coverva.org/programs_premium_assistance.cfm)  
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CHIP Phone: 1-855-242-8282

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**Paperwork Reduction Act Statement**

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)
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October 3, 2019

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
- Prostheses (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.

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](http://www.IPTT.org).

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

Introduction

You are receiving this notice because you have recently become covered under the Idaho Pipe Trades Trust Health and Welfare Fund (“The Fund”). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan’s Summary Plan Description or get a copy of the Plan Document from the Fund Office.

The Plan administrator is BeneSys Administrators (the “Fund Office”) located at PMB#116, 5331 SW Macadam Avenue, Suite 258, Portland, OR 97239. You can call the office at (208) 288-1610 or (800) 808-1687. The Plan administrator is responsible for administering COBRA continuation coverage.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than your gross misconduct.
If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse’s hours of employment are reduced;
3. Your spouse’s employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes enrolled in Medicare (Part A, Part B or both); or
5. You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

1. The parent-employee dies;
2. The parent-employee’s hours of employment are reduced;
3. The parent-employee’s employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the plan as a “dependent child.”

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events.

For other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You may send written notice of the event to: Idaho Pipe Trades Trust Fund, PMB#116, 5331 SW Macadam Avenue, Suite 258, Portland, OR 97239 or you can report a qualifying event by calling the Fund Office at (208) 288-1610 or (800) 808-1687 and speaking to a representative in the eligibility department. You will be required to send a full copy of your divorce decree or documentation of your legal separation to the Fund Office at: PMB#116, 5331 SW Macadam Avenue, Suite 258, Portland, OR 97239.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the qualifying event.
COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both) your divorce or legal separation, or dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee’s hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

**Disability Extension Of 18-Month Period Of Continuation Coverage**

If you or anyone in your family covered under the plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the Social Security Administration’s determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent along with a copy of the Social Security Administration’s determination to the Idaho Pipe Trades Trust Fund, PMB#116, 5331 SW Macadam Avenue, Suite 258, Portland, OR 97239.

**Second Qualifying Event Extension of 18-month Period of Continuation Coverage**

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to: Idaho Pipe Trades Trust Fund, PMB#116, 5331 SW Macadam Avenue, Suite 258, Portland, OR 97239, or you can report a qualifying event by calling the Fund Office at (208) 288-1610 or (800) 808-1687 and speaking to a representative in the eligibility department. You will be required to send a full copy of your divorce decree or documentation of your legal separation, or Medicare Card to the Fund Office at: PMB#116, 5331 SW Macadam Avenue, Suite 258, Portland, OR 97239.
If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the Fund Office by calling (208)288-1610 or (800)808-1687. Written correspondence should be sent to: Idaho Pipe Trades Trust Fund, PMB#116, 5331 SW Macadam Avenue, Suite 258, Portland, OR 97239. You may also contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA offices are available through EBSA’s website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your family’s rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.
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).


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.
<table>
<thead>
<tr>
<th>Language</th>
<th>Message About Language Assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Español</td>
<td>ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1 (800) 808-1687.</td>
</tr>
<tr>
<td>Chinese</td>
<td>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.</td>
</tr>
<tr>
<td>Deutsch</td>
<td>ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1 (800) 808-1687.</td>
</tr>
<tr>
<td>Tiếng Việt</td>
<td>CHÚ Ý: Nếu bạn nói Tiếng Việt, có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1 (800) 808-1687.</td>
</tr>
<tr>
<td>Korean</td>
<td>주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1 (800) 808-1687 전화해 주십시오.</td>
</tr>
<tr>
<td>Arabic</td>
<td>ملحوظة: إذا كنت تتحدث اللغة، فإن خدمات المساعدة اللغوية تتوفر لك بالمجمل. اتصل برقم 1 (800) 808-1687.</td>
</tr>
<tr>
<td>French</td>
<td>ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1 (800) 808-1687.</td>
</tr>
<tr>
<td>Serbo-Croatian</td>
<td>OBAVJEŠtenje: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1 (800) 808-1687</td>
</tr>
<tr>
<td>Filipino</td>
<td>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</td>
</tr>
<tr>
<td>Ukrainian</td>
<td>УВАГА! Якщо ви розмовляете українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1 (800) 808-1687</td>
</tr>
<tr>
<td>Romanian</td>
<td>ATENŢIE: Dacă vorbiți în limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1 (800) 808-1687</td>
</tr>
<tr>
<td>Russian</td>
<td>ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1 (800) 808-1687.</td>
</tr>
<tr>
<td>Adamawa Fulfulde</td>
<td>MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ek kitaaki wolde caahu. Noddu 1 (800) 808-1687</td>
</tr>
<tr>
<td>Farsi</td>
<td>توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (800) 808-1687 تماس بگیرید.</td>
</tr>
</tbody>
</table>

**Attention:** For free language assistance, call 1 (800) 808-1687

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**Note:** 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。