WISCONSIN PIPE TRADES HEALTH FUND

BENEFIT HIGHLIGHTS SUMMARY

April 2017

Please Note – This document contains a summary of benefits only. Services are subject to medical necessity (except preventive care) and may be subject to limitations. Please refer to your Summary Plan Description (SPD), Benefit Bulletins, Notices, Summaries of Material Modifications (SMMs) and Summaries of Benefits and Coverage (SBCs), or contact the Fund Office for information about limitations and exclusions.

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Eligibility Requirements[1]

Employee Class	Initial Eligibility	Continued Eligibility
Class A (active employees) & **Class JD** (full-time pre-apprentices, first and second year apprentices, maintenance tradesmen, and warehousemen)	First day of the Coverage Month following the corresponding Work Month during which contributions are credited on the employee's behalf for 145 hours of work for a contributing employer for coverage under Plan A and 125 hours for Plan B.	Eligibility is maintained by being credited with employer contributions for at least 145 hours per month to continue coverage under Plan A, 125 hours per month to continue coverage under Plan B, and 90 hours per month to continue coverage under Plan C.[2]

The corresponding Work Months and Coverage Months are as follows:

Hours Worked During the Month of…	Provide Coverage for the Month of…
January	April
February	May
March	June
April	July
May	August
June	September
July	October
August	November
September	December
October	January
November	February
December	March

[1] If employer contributions have not been made on your behalf and you believe you have worked enough hours to become initially eligible, please contact the Fund Office for verification.

[2] If you become sick, disabled, retire or die, self-payments may be made to maintain eligibility. If you worked for another fund that has a reciprocity agreement with this Fund, it may reduce or cancel a self-payment you otherwise would be required to make.

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Benefit Highlights[1]

For Plans A, B, and C			
Benefit Description	Classes A and JD		
Death Benefit (Employee only)	$5,000		
Accidental Death and Dismemberment Benefit (Employee only)	$5,000		
Loss-of-Time Weekly Benefit (Employee only)-- Maximum 26 weeks per period of disability	$ 300		
Comprehensive Major Medical Benefits for hospital services, physicians' services, certain prescription drugs, x-ray and lab services, and other covered items and services when medically necessary, subject to the following. *(Please Note: The terms "medically necessary" and "medically appropriate" are used interchangeably.)*	Comprehensive Plan (Plan A)	Basic Plan (Plan B)	Catastrophic Plan (Plan C)
Calendar year deductible[2,3]			
In-network			
Per eligible person	$ 1,000	$ 3,890	$ 4,500
Per family	$ 3,000	$ 7,780	$ 9,000
Out-of-network			
Per eligible	$ 2,000	$ 4,200	$ 9,000
Per family	$ 6,000	$ 8,400	$18,000
Out-of-pocket maximum[3]			
Per calendar year for covered expenses, including deductible amount or specific dollar amount copayments for emergency room visits and physicians' office visits (including outpatient physician visits at a hospital and home visits by a physician)			
In-network			
Per eligible person	$ 3,600	$ 4,500	$ 4,500
Per family	$ 7,200	$ 9,000	$ 9,000
Out-of-network			
Per eligible person	$ 7,200	$ 9,200	$ 9,000
Per family	$14,400	$18,400	$18,000
The Plan pays 100% of covered charges in excess of such maximum for remainder of that calendar year.			

[1] All benefits and eligibility rules outlined in this summary are subject to review and changes by the Board of Trustees.

[2] If both a husband and wife are eligible under the Plan as employees, the Comprehensive Major Medical Benefits deductible amount will be waived for the entire family.

[3] All PEAR (for Pathologists, Emergency room physicians, Anesthesiologists, and Radiologists) group and hospitalist charges incurred while hospitalized or receiving outpatient treatment in a network hospital are payable at the in-network level of benefits. In addition, benefits are payable at the in-network level of benefits for: emergency room services at an out-of-network hospital (and for subsequent hospitalization if an emergency admission occurs and you were transported to the hospital via ambulance); and out-of-network lab charges if you went to an in-network physician and facility.

For Plans A, B, and C			
Benefit Description	Classes A and JD		
	Comprehensive Plan (Plan A)	Basic Plan (Plan B)	Catastrophic Plan (Plan C)
Plan's coinsurance of covered expenses[1]			
Inpatient and outpatient			
In-network	80%	80%	100%
Out-of-network	60%	60%	100%

Routine physical exam for employee and spouse only, 100% at PPO; at non-PPO: subject to Comprehensive Major Medical Benefits deductible and coinsurance, up to maximum (Routine physical exam charges at non-PPO in excess of $400 maximum payable at 20%)[2]	$400 maximum per person per calendar year - or - 100% of actual fee through Health Dynamics	
Pre-admission testing, second surgical opinions, routine immunizations, well child care (at non-PPO only: 80%; birth to age two-no maximum/age 2 through 17 - one preventive care exam and associated routine lab charges per calendar year; dependent children age 18 to 26 - preventive care exams and related lab and x-ray charges up to $400 per calendar year and then at 20%)[2], hospice care, home health care (up to 10 visits per period of disability), and skilled nursing home care (up to 30 days of confinement per period of disability)	100% of reasonable expenses; not subject to deductible	
Hospital emergency room Separate dollar copayment per visit after deductible and before applicable coinsurance percentage (waived if admitted)	**Plans A & B**	**Plan C**
	$100	$0
Physician office visits (including outpatient physician visits at a hospital and home visits by a physician) Eligible person's copayment per visit (deductible and other coinsurance do not apply)	$25	$0

[1] All PEAR (for Pathologists, Emergency room physicians, Anesthesiologists, and Radiologists) group charges incurred while hospitalized or receiving outpatient treatment in a network hospital are payable at the in-network level of benefits. In addition, benefits are payable at the in-network level of benefits for emergency services if transported to a hospital via ambulance and for subsequent hospitalization if an emergency admission occurs.

[2] Your 80% coinsurance for routine physical exam charges and well child care in excess of the $400 maximum will not apply to the out-of-pocket maximum.

	Plans A & B	Plan C[1]
Benefit Description	Classes A and JD	
Treatment of nervous and mental disorders		
Hospital confinement:		
Plan's coinsurance	90%	100%
Partial hospitalization (including residential treatment and intensive outpatient treatment):		
Plan's coinsurance	90%	100%
Outpatient treatment:		
First 30 visits per eligible person per calendar year		
Plan's coinsurance	100%	100%
After 30 visits, eligible person's copayment per visit	$25	N/A
Treatment of substance abuse and alcoholism		
Hospital confinement:		
Plan's coinsurance	90%	100%
Partial hospitalization (including residential treatment and intensive outpatient treatment):		
Plan's coinsurance	90%	100%
Outpatient treatment:		
Plan's coinsurance	100%	100%
Genetic testing (including BRCA testing) when medically necessary	$5,000 per lifetime	$5,000 per lifetime
Wigs Covered at the in-network level Maximum per eligible person per calendar year	$750	$750

[1] For Plan C, the Plan pays 100% of charges after respective in/out-of-network deductibles and out-of-pocket maximums have been satisfied. Benefits payable at in-network level for out-of-network hospital (including resulting hospital charges if admitted and if had been transported by ambulance).

	Plans A & B	Plan C[1]
Benefit Description	Classes A and JD	
Preferred Provider Pharmacy Prescription Drug Benefits[2]		
Deductible per eligible person per calendar year (does not apply to omeprazole 20mg capsule, and OTC Prilosec and OTC loratadine upon a physician's written prescription)	$100	$250
Eligible person's copayment[3,4]		
Retail network pharmacy per prescription for up to a 30-day supply	Generic: $13 Brand Name: 20% coinsurance, with a minimum copayment of $26 and a maximum of $52 [50% of the cost of the prescription for prescription Proton Pump Inhibitors (PPIs) and prescription non-sedating antihistamines]	Generic: $20 Brand Name: 20% coinsurance, with a minimum copayment of $30 and a maximum of $60 [50% of the cost of the prescription for non-generic prescription Proton Pump Inhibitors (PPIs) and prescription non-sedating antihistamines]
Mail-service per prescription for up to a 90-day supply	Generic: $13 Brand Name: $32.50	Generic: $20 Brand Name: $50
Specialty medications per prescription for up to a 30-day supply	$13	$100
Retail network pharmacy or mail-service for generic OTC medications in the following categories: non-sedating antihistamines, proton pump inhibitors, and proton pump inhibitor-antacid combinations, upon a physician's written prescription	$0	No charge, no deductible
Out-of-pocket maximum per calendar year		
Per eligible person Per family	$2,350 $4,700	$2,350 $4,700

[1] For Plan C: all Pharmacy Benefits listed are for services obtained at an in-network provider. All Preferred Provider Pharmacy services obtained at an out-of-network provider are not covered.

[2] Maintenance medications must be purchased through mail-service. Step Therapy Program applies to medications for asthma, diabetes, ADHD, and cholesterol. Drugs not on the formulary list are not covered.

[3] Use of generics is a mandatory requirement.

[4] Upon a physician's written prescription, the following will be covered at a $0 copayment: generic contraceptives and contraceptives for which there is no generic alternative; OTC generic aspirin up to 325mg once per day for age 45 and older; federal legend generic sodium fluoride for five and younger; OTC generic folic acid for doses of 0.4mg-0.8mg once per day for women age 55 and younger; OTC iron supplements up to age one; OTC generic vitamin D (400IU) twice per day for age 65 and older; and FDA-approved tobacco cessation medications (including both prescription and OTC medications) for a 90-day treatment regimen when prescribed by a health care provider, with no requirement for prior authorization.

Benefit Description	**Plans A & B:** Classes A and JD[1]		
	Delta Dental Plan		Care-Plus
Dental Benefits	PPO	Non-PPO	
Exams and cleanings (maximum 2 per calendar year), basic dental benefits, and full denture replacement benefits (every 5 years)			
Deductible	None	None	None
Plan's coinsurance	90%	80%	100% (diagnostic & preventive); 80% (restorative, crowns, prosthodontics, endodontics, periodontics, & oral surgery)
Maximum benefit per eligible person per calendar year	$1,000[2]		$1,500[2]
Orthodontic			
Deductible	None	None	None
Plan's coinsurance	100%	100%	50%
Maximum lifetime benefit per eligible person	$1,500		$3,000 (to age 19)
Vision Care Benefits, per person			
Exam (maximum 1 per calendar year)	$40[3]		
Lenses, including contact lenses, and frames (maximum each 2 calendar years)	$300		
Safety glasses (maximum 1 set per calendar year – employee only)	$60		

[1] **Plan C:** provides limited Dental Benefits of two dental exams and cleanings per calendar year for children under age 19.

[2] The following services will not be subject to the calendar year maximum for dependent children under age 19 covered under the Delta Dental Plan only: routine dental examinations, limited to two exams per calendar year, including bitewing x-rays once each calendar year; dental prophylaxis, limited to two per calendar year; topical fluoride applications, limited to two applications each calendar year; dental sealant applications; and fillings – amalgams or composite restorations.

[3] Vision exam maximum does not apply to dependent children under age 19. **Plan C:** provides limited Vision Care Benefits of one exam per calendar year for children under age 19.