Local 60 Health & Welfare Fund: Active

Coverage Period: 01/01/2017 – 12/31/2017

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

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at by calling 1-914-769-2440.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Out-of-network (OON): Basic Hospital Benefits $300/person per admission; Major Medical OON: $200/person & $600/family.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. The **deductible** starts over January 1st; See chart on page 2 for how much you pay for covered services after you meet the deductible. Co-payments, balance billing, excluded services, co-insurance amounts do not count toward these deductibles.
Are there other deductibles for specific services?	Yes, $50/person Dental. This deductible does not apply to preventative services.	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.
Is there an out–of–pocket limit on my expenses?	Yes. OON Basic Hospital: $3,000/person & $7,500/family. Major Medical: $1,250/person	The out-of-pocket limit is the most you could pay during a coverage period (one calendar year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Balance billing, health care this Plan does not cover, co-payments, deductibles, penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they do not count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Hospital and Medical: www.empireblue.com Prescription: www.express-scripts.com	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider**, for some services. Plans use the term in-network, preferred or participating for **providers** in their **network**. See chart on page 2 for how plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this Plan.
Are there services this	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your Plan Booklet for additional information about excluded services.

Questions: Call 1-914-769-2440. If you aren't clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at www.cciio.cms.gov or call 1-914-769-2440 to request a copy.

plan doesn't cover?		

- **Copayments** are fixed dollar amounts (for example, $10) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 co-payment	20% co-insurance	None
	Specialist visit	$10 co-payment	20% co-insurance	None
	Other practitioner office visit	$10 co-payment	20% co-insurance	$1,250 annual maximum for chiropractic & podiatry services
	Preventive care/screening/immunization	$10 co-payment	20% co-insurance	Plan allows one well visit/calendar year
If you have a test	Diagnostic test (x-ray, blood work)	hospital:$100 copay other: no copay	30% co-insurance; 20% co-ins hosp.	Pre-certification required for test > $350. No pre-cert=penalty or denial
	Imaging (CT/PET scans, MRIs)	hospital:$100 copay other: no copay	30% co-insurance; 20% co-ins hosp.	Pre-certification required for test > $350. No pre-cert=penalty or denial

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** call Express Scripts at 1-844-520-2679 or visit the website **www.express-scripts.com.**	Generic drugs	No charge	No charge	90 day supply maximum/prescription. After applicable copayment, first $2,000 of Rx drug charges for individual & $3,500 for family reimbursed 100% by Plan. Rx drug charges between $2,000 & $7,000 for Individual and $3,500 & $13,500 for Family are 100% participant coinsurance. Rx drug charges over $7,000 for Individual & $13,500 for Family is 80% participant coinsurance.
	Preferred brand drugs	$25 co-payment	$25 co-payment	
	Non-preferred brand drugs	$25 co-payment	$25 co-payment	
	Specialty drugs	Brand: $25 copay Generic: no copay	Brand: $25 copay Generic: no copay	After applicable copayment, first $20,000 of IV Therapy drug charges 100% reimbursed by plan. IV Therapy drug charges between $20,000 & $30,000 is 100% participant coinsurance. IV Therapy drug charges over $30,000 is 80% participant coinsurance. Must be FDA approved for the condition it is being prescribed.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 co-payment	30% co-insurance	Pre-certification required
	Physician/surgeon fees	No Charge	20% co-insurance	Pre-certification required
If you need immediate medical attention	Emergency room services	$100 copay	$100 copay	Waived if admitted to a hospital within 24 hours
	Emergency medical transportation	No charge	20% co-insurance	$3,000 limit for helicopter transport
	Urgent care	$10 copay	20% co-insurance	None

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay	30% co-insurance	Semi-private room, pre-cert required.
	Physician/surgeon fee	No charge	20% co-insurance	Surgery must be pre-certified.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	office: $10 copay; out-patient hospital:$100 copay	office: 20% co-insurance; outpatient hospital 30% co-insurance	Pre-cert required for in & out-patient services. If hospital stay exceeds 120 days, you pay 20% co-insurance after meeting major med deductible.
	Mental/Behavioral health inpatient services	$100 copay	30% co-insurance	
	Substance use disorder outpatient services	office: $10 copay hospital: $100 copay	office: 20% co-insurance; outpatient hospital 30% co-insurance-	Dependents are not covered. Pre-cert required for in & out-patient substance use disorder benefits. If hospital stay exceeds 120 days, you pay 20% co-insurance after meeting major med deductible.
	Substance use disorder inpatient services	$100 copay	30% co-insurance	
If you are pregnant	Prenatal and postnatal care	$10 copay	20% co-insurance	Not covered for dependent children
	Delivery and all inpatient services	$100 copay	30% co-insurance	Not covered for dependent children
If you need help recovering or have other special health needs	Home health care	No charge	20% co-insurance	Pre-cert required, 200 visit /year , 4 hours equals one visit
	Rehabilitation services	office: $10 copay hospital: $100 copay	20% co-insurance 30% co-insurance	Pre-certification required
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	Not covered	Not covered	Not covered
	Durable medical equipment (DME)	No charge	20% co-insurance	First $1,500 usual, reasonable, customary (UCR) paid by Plan, between $1,500 & $11,500 is 100% participant coinsurance. DME charges over $11,500 is 80% participant coinsurance. Pre-cert & medical necessity required
	Hospice service	Not covered	Not covered	Not covered
If your child needs	Eye exam	Charges over $50	Charges over $50	Plan allows one exam/yr. up to $50.00

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If your child needs dental or eye care	Glasses	Charges over $100	Charges over $100	Plan allows one pair of glasses/contacts per year up to $100.00
	Dental check-up	Amount over plan's schedule allowance		Annual dental max $1,800/person $50 annual deductible for non-preventative covered dental services.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery (unless medically necessary)
- Cosmetic surgery
- Infertility treatments
- Long-term care services
- Non-emergency care when traveling outside the USA
- Private-duty nursing (unless medically necessary)
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care (2 x-rays & $1,250/person annual individual maximum).
- Dental care (Member & dependents) Annual $1,800 annual individual maximum).
- Hearing aids (up to $850/member & $350/dependent, every 24 months).
- Routine eye care (Members & dependents) $50/exam & $100 for lenses/frames/contacts per calendar year).
- Routine foot care (Podiatry services: $1,250 annual maximum/person/calendar year).
- Physical, Speech & Occupational Therapy (combined 26 visit /person/calendar year. These services require pre-certification).

Your Rights to Continue Coverage:

If you lose coverage under this plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-914-769-2440. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 X 61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: the Fund Office at 1-914-769-2440. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-914-769-2440

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,290
- **Patient pays** $ 250

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$100
Coinsurance	$0
Limits or exclusions	$150
Total	**$250**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,100
- **Patient pays** $ 1,300

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$60
Coinsurance	$0
Limits or exclusions	$1,240
Total	**$1,300**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.