IUOE Local 132 Health & Welfare Fund

Coverage Period: 07/01/2015 – 06/30/2016

Active Participants and Non-Medicare Retirees

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

Coverage for: Individual + Dependents | **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 www.iuoe132.org or by calling 1-304-525-0482 or 1-800-642-3525.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$250** person / **$500** family Doesn't apply to preventive care	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your Summary Plan Description to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$100** for prescription drug coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$3,000** for participating providers / **$6,000** for non-participating providers.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. See **www.anthem.com or call 1-800-810-2583** to locate participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a **specialist**.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan does not cover are listed on page 5. See your Summary Plan Description for additional information about **excluded services**.

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

Questions: Call 1-304-525-0482 or 1-800-642-3525 or visit us at www.iuoe132.org.
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.iuoe132.org or call 1-304-525-0482 or 1-800-642-3525 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use 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	15% coinsurance	30% coinsurance	none
	Specialist visit	15% coinsurance	30% coinsurance	none
	Other practitioner office visit	15% coinsurance	30% coinsurance	Chiropractic care is limited to a maximum of 20 visits or a total of $1,000 per calendar year, whichever occurs first
	Preventive care/screening/immunization	$0	$0	First $1,000 paid at 100%, then 50% thereafter
If you have a test	Diagnostic test (x-ray, blood work)	$0	30% coinsurance	Must be a free-standing laboratory for the Participating Provider charges to be paid at 100%, if it is not a free-standing laboratory, Participating Provider charges require 15% coinsurance
	Imaging (CT/PET scans, MRIs)	15% coinsurance	30% coinsurance	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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.iuoe132.org.	Generic drugs	10% of cost ($7.50 min / $100 max) $20 for 90-day supply		Covers up to a 30-day supply (retail prescription) at any network pharmacy Covers up to a 90-day supply at any CVS/pharmacy or CVS Caremark Mail Service Pharmacy
	Preferred brand drugs	20% of cost ($20 min / $100 max) $40 for 90-day supply		
	Non-preferred brand drugs	30% of cost ($35 min / $100 max) $80 for 90-day supply		
	Specialty drugs	Dependent on if specialty drug is generic, brand or non-preferred brand		Requires pre-authorization and the use of the CVS Caremark Specialty Pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	30% coinsurance	none
	Physician/surgeon fees	15% coinsurance	30% coinsurance	none
If you need immediate medical attention	Emergency room services	15% coinsurance	30% coinsurance	none
	Emergency medical transportation	15% coinsurance	30% coinsurance	none
	Urgent care	15% coinsurance	30% coinsurance	none
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	30% coinsurance	none
	Physician/surgeon fee	15% coinsurance	30% coinsurance	none
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	15% coinsurance	30% coinsurance	none
	Mental/Behavioral health inpatient services	15% coinsurance	30% coinsurance	none
	Substance use disorder outpatient services	15% coinsurance	30% coinsurance	none
	Substance use disorder inpatient services	15% coinsurance	30% coinsurance	none
If you are pregnant	Prenatal and postnatal care	15% coinsurance	30% coinsurance	none
	Delivery and all inpatient services	15% coinsurance	30% coinsurance	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 need help recovering or have other special health needs	Home health care	15% coinsurance	30% coinsurance	none
	Rehabilitation services	15% coinsurance	30% coinsurance	none
	Habilitation services	15% coinsurance	30% coinsurance	none
	Skilled nursing care	15% coinsurance	30% coinsurance	none
	Durable medical equipment	15% coinsurance	30% coinsurance	none
	Hospice service	15% coinsurance	30% coinsurance	none
If your child needs dental or eye care	Eye exam	For children age 19 or less, the oral/vision care benefit pays 100% of the first $750, then 50% thereafter		For adults, the oral/vision care benefit is limited to a maximum of $750 per calendar year
	Glasses and/or contacts			
	Dental check-up			

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.)

- Bariatric surgery (if BMI less than 40)
- Cosmetic surgery, unless necessary as a result of an accident or congenital birth defect
- Hearing aids
- Infertility treatment
- Routine Foot Care

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

- Acupuncture (if prescribed for rehabilitation purposes
- Chiropractic care (up to $1,000 per year or twenty visits, whichever occurs first)
- Dental Care (Adult or Child)
- Long term care
- Most coverage provided outside the United States
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (Adult or Child)
- Weight loss programs (if BMI greater than 40)

Your Rights to Continue Coverage:

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

For more information on your rights to continue coverage, contact the plan at (304) 525-0482 or 1-800-642-3525. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov."

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Fund Office at 1-304-525-0482 or 1-800-642-3525.

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.**

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

About these Coverage Examples:

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

This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,160
- **Patient pays** $1,380

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	$250
Copays	$0
Coinsurance	$980
Limits or exclusions	$150
Total	**$1,380**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,340
- **Patient pays** $1,060

Sample care costs:

Prescriptions	$2,800
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$5,400**

Patient pays:

Deductibles	$250
Copays	$0
Coinsurance	$730
Limits or exclusions	$80
Total	**$1,060**

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.